4600.00.00 BENEFIT RECOVERY

This chapter presents policy and procedures on the following:

Identifying Over Issuances (Section 4605);

Types of Over Issuances (Section 4610);

Time Limits for Over Issuance Referrals (Section 4615);

Over Issuance Calculation (Section 4620);

Persons Responsible for Repayment (Section 4625);

Initiating Collection Action (Section 4630);

Recovery Methods (Section 4635);

Transmittal of Repayment (Section 4640);

Ending Collection Activity (Section 4645);

Claim Against Estate (Section 4650); and

Tracking IPV Disqualifications (Section 4655); and

Footnotes for Chapter 4600 (Section 4699).

4605.00.00 IDENTIFYING OVER ISSUANCES

An over issuance exists when an AG received benefits when it was not eligible to receive benefits, when the AG received benefits in an amount greater than it was eligible to receive or, for Food Stamps only, when any benefits were trafficked. Trafficking is the buying or selling of Food Stamp coupons or EBT Food Stamp benefits for cash or consideration other than eligible food. (f1)

The claims process begins with the identification of an over issuance. This occurs when the caseworker receives or discovers information which appears to contradict information previously used to determine eligibility.

The caseworker may receive information that an over issuance has occurred as a result of:

an untimely reported change;

information from individuals inside/outside the AG;

fair hearing decision;

Quality Control (QC) referral;

Management Evaluation (ME) review;

Office of Inspector General (OIG) investigation/audit report (referred through Central Office); or

Central Office referral.

The source reporting information may have already conducted a case file review and obtained documentation to resolve the discrepancy and determine the time period and amount of any over issuance.

The caseworker may also discover information contrary to what is in the case file from review of reports from one of the following sources:

Department of Workforce Development (through data exchange);

Social Security Administration (SSA) (through data exchange);

Internal Revenue Service (IRS) (through data exchange);

State generated computer printouts (FSPR 7-02);

Bureau of Motor Vehicles (BMV); or

financial institutions.

Over issuances may also occur in the following situations:

action on a reported change which was not implemented or was not implemented timely;

data input errors are identified;

errors in benefit calculation are discovered;

continued benefits received pending release of a hearing decision; or

failure to implement a change in regulation.

4605.05.00 STAFF RECOVERY RESPONSIBILITIES

Recovery responsibilities of the eligibility worker and supervisor, the benefit recovery (BV) worker and BV supervisor and the Fraud Referral Coordinator are provided in the following sections. In some counties the eligibility workers and supervisors may also have the benefit recovery worker or BV supervisor or Fraud Referral Coordinator profile.

4605.05.05 Caseworker Responsibilities

When a possible over issuance is identified, the caseworker must gather and record the following information in running record comments or in the paper casefile:

the cause of the over issuance;

how the over issuance was discovered;

the date the agency became aware of an over issuance;

who received the income/resource/status change;

the date the income or change started and/or stopped;

the estimated length of over issuance;

any explanation given for failure to provide information accurately or in a timely manner;

corrective action taken and the date such action was taken; and

instances involving misuse of food stamp benefits or EBT cards (the dates and source of the referral must be recorded).

Before completing a referral to the BV unit the caseworker must review the above information to determine what further information/verification is still needed and take the actions listed below.

Obtain verification necessary to determine the time period and the amount of over issuance;

Adjust the current benefit, if appropriate, prior to referral to Benefit Recovery;

Verify that the individual was actually receiving assistance, using screens IQFS, IQCH, and IQMD, during the time the claim was presumed;

Advise the AG in writing that a discrepancy exists, that the source of the discrepancy is from outside the AG and that a referral to BV will be made regarding the overpayment if the discrepancy cannot be resolved. If discrepancy is identified through the data exchange (DE) subsystem, the discrepancy notice can be generated through the DE screen. Form 2244 can be used for other discrepancies.

If the over issuance is referred to the prosecutor, do not discuss the possibility of repayment with any member of the AG before the final court disposition.

The AG will be allowed 10 days to rebut the allegation prior to referral to BV. The caseworker must allow the AG an opportunity to provide information which clarifies the situation.

The caseworker must also:

complete the Benefit Recovery Referral (BVBR) screen within 30 calendar days of the day the agency became aware of the overpayment; (Refer to Section 4620.00.00, Completing the Benefit Recovery Referral)

respond to the BV unit requests for any additional information within 10 calendar days;

For Food Stamps and TANF only, rerun the eligibility determination/benefit calculation (ED/BC) when alerted by BV to initiate automatic benefit reduction effective no later than 10 calendar days from receipt of the alert;

rerun the benefit calculation to implement an AG member's disqualification within 10 working days of receipt of BV's alert to disqualify the AG member;

if notified that a payment has been received and no referral exists, determine if over issuance occurred and enter information on BVBR; (refer to Section 4620.00.00, Completing the Benefit Recovery Referral)

if notified that a payment has been received and no over issuance exists, the payment must be returned to the individual;

NOTE: At no time should the caseworker accept a repayment whether in cash, check, money order, certified check or food coupons. Any payments should be made to the Accounting Department, designated BV supervisor, or a bookkeeper.

when notified that attendance is required, prepare for appearance in court, a hearing, or for Food Stamps and TANF, only, an Administrative Disqualification Hearing (ADH).

If over issuance was discovered as a result of Data Exchange, follow the policy in Section 4415.05.00, IEVS Compliance Tracking, prior to referral to Benefit Recovery (BV).

4605.05.10 Benefit Recovery Worker Responsibilities

The Benefit Recovery (BV) caseworker is responsible for the establishment of all over issuance claims and the maintenance of all recoupment and recovery activities except the receipt of any repayments.

4605.05.15 Fraud Referral Coordinator Responsibilities

Each local office has identified a Fraud Referral Coordinator (FRC) to serve as the contact for all fraud, investigation and referral activity.

The responsibilities of the Fraud Referral Coordinator are:

Review all claims purported to be fraud before they can be opened. Decide on further action.

Monitor all fraud referral and investigation activities conducted within the local office.

Serve as contact for central office staff on matters related to claims, collections, adjudications and investigations.

Maintain all fraud activity records including Fraud Hotline Referrals, other program abuse complaints, referrals for investigations, prosecutions, Administrative Disqualification Hearings, and criminal court results. Assign FIST investigation numbers to all referrals to be investigated by county or Compliance Division. Use the FIST software to report results monthly to the central office.

Review all referrals for investigation. When appropriate, e-mail them to the Compliance Division at Fraud Referral (e-mail address). Continue to use Fraud Referral to the Bureau of Investigation, form FI0013, which is available on line. The district 'North' or 'South' should be entered on the subject line of the e-mail address. The necessary screens and a copy of the referral can then be picked up by the investigator assigned to the case.

Review any local office requests for EBT transactions. The e-mail form must come from a FRC or an Investigator. E-mail to the Central Office BV Coordinator. The latest three months are on BOSS. Transaction history is not necessary to prove benefits were “issued”. See Section 4620.10.00 under ‘NOTE’.

Review all completed investigations to determine the appropriate action to be taken on the case. Whenever possible, seek adjudication. Review resulting claims and enter in FIST along with adjudication results.

4610.00.00 TYPES OF OVER ISSUANCES

Once an over issuance is identified, the reason for the over issuance must be identified.

An over issuance may be the result of:

Agency Error;
Inadvertent Error;
Intentional Program Violation (fraud); or
any combination of the above. A Medicaid claim cannot be adjudicated as IPV in an Administrative Disqualification Hearing, and even if a Medicaid claim is part of a Prosecution case found guilty, it must be entered in ICES as 'CE'. (See Section 4610.10.00.)

In addition, there is one sub-type, PPV (Pending Program Violation. This type is used for Food Stamps only in just one situation:

- The claim is scheduled to go for an Administrative Disqualification Hearing, not to the county Prosecutor

- The client is currently receiving benefits

In that situation, the claim is opened prior to the ADH as PPV and recoupment is initiated as an IE claim until the adjudication process is completed and the type is changed to IPV.

4610.05.00 AGENCY ERROR DEFINITION

An Agency Error (AE) claim is any claim for an overpayment caused by an action or failure to take action by the Division of Family and Children.

An agency error over issuance can occur as a result of:

a misapplication of policy;

a calculation error;

a computer processing error;

failure to take prompt action on available information;

some other error over which DFC has control.

4610.05.05 Agency Errors Not Requiring A Referral (F)

A claim will not be established for the sole reason that the Local Office failed to ensure that an AG:

signed the application form;
completed a current work registration form;
was certified in the correct project area;
completed a timely review; or
was asked to provide a required form for completion.

In addition, a claim will not be established for the reason that the AG failed to report a change that it was not required to report, including Simplified Reporting Changes.

4610.10.00 INADVERTENT ERROR DEFINITION

Inadvertent error is an over issuance caused by a misunderstanding or an unintended error on the part of the AG. Caseworkers can help to eliminate this type of error by making sure the client understands what is needed and by what date. Caseworkers can also help by being well organized, so that reported changes are always acted upon and never lost. ICES coding remains unchanged. A Medicaid or TANF error of this type is coded CE and a Food Stamp error of this type is coded IHE. Food Stamp letters sent to clients now use the new nomenclature.

For TANF or Food Stamps, a claim in which fraud is suspected is categorized as an inadvertent error until a fraud finding is established by an administrative hearing decision or a court of appropriate jurisdiction.

An inadvertent error can occur as a result of:

AG failure to provide correct or complete information;

AG failure to report required changes in the AG's circumstances; and

AG receipt of benefits (or more benefits than it was entitled to receive) pending a fair hearing decision.

4610.15.00 SUSPECTED FRAUD DEFINITION

Fraud is the act whereby a person willfully and deliberately makes false statements or suppresses facts or gives information which misrepresents the true circumstances regarding himself or others for the purpose of receiving assistance to which there is not entitlement.

Suspected fraud over issuances can occur as a result of the AG:

misrepresenting information;

concealing information;

withholding information pertinent to determining eligibility, including untimely reporting;

failing to report a change in order to continue to receive benefits for which the AG was not entitled; or

intentionally altering or changing documents to obtain benefits to which the AG was not entitled.

Fraud, in all of its aspects, is a matter of legal determination. Therefore, fraud does not exist until this legal determination has been made through the criminal or civil court or the administrative hearing system.

Once the suspected fraud claim has been calculated **but not yet opened**, the entire claim case file will be submitted to the Fraud Referral Coordinator for review and approval.

4610.15.05 Intentional Program Violation Definition (F, C)

An Intentional Program Violation (IPV) is the act of deliberately, intentionally making a false or misleading statement or misrepresenting, concealing, or withholding facts from the Local Office for the purpose of establishing or maintaining benefit eligibility or increasing or preventing a reduction in the amount of the benefit. (f2)

In addition to those examples of suspected fraud listed in the preceding section, an alleged Food Stamp IPV may also exist if the AG:

intentionally used coupons or an EBT card to buy nonfood items (such as alcohol, cigarettes, drugs, weapons, ammunition or explosives);

intentionally used or possessed improperly obtained coupons or EBT card;

intentionally traded or sold coupons or EBT Food Stamp benefits for cash or consideration other than eligible food. (This is client trafficking); or

intentionally committed any act that constitutes a violation of the Food Stamp Act, the Food Stamp Program Regulations, or any state statute relating to the use, presentation, transfer, acquisition, receipt, or possession of Food Stamp coupons or EBT Food Stamp benefits.

An IPV determination must be made through court action or an Administrative Disqualification Hearing (ADH) or a signed ADH waiver. For lengths of disqualification, refer to Section 4610.40.10 for Food Stamp penalties and Section 4610.40.15 for TANF penalties.

4610.15.10 Deterrents Against Fraudulent Activity

The Local Office is to establish deterrents against fraudulent activity through:

skilled investigation;

careful explanation of all eligibility requirements to applicants/recipients;

diligent use of collaterals and other sources of information;

verification of facts;

alertness to possible misunderstandings;

follow-up investigations where indicated;

establishment of procedures for handling cases of suspected fraud to ensure thorough investigation and proper referrals to the County Prosecutor or Administrative Disqualification Hearing; and

cooperation with the news media in publicizing cases prosecuted for welfare fraud.

4610.15.15 Establishment And Investigation Of Possible Fraud

Documentation of the applicant's/recipient's apparent ability or inability to understand questions regarding eligibility, especially with regard to income and resources, must be entered in the running record comments. It is unlikely that fraud can be established and substantiated if the documentation shows that the individual's mental or physical condition resulted in his inability to understand

eligibility requirements and his responsibility to provide information to the Local Office.

The caseworker may suspect fraud exists within an AG. Some clues which may indicate unwarranted receipt of assistance are:

- purchase of items which indicate that more income exists than is known;
- living at a higher standard than known income would permit;
- unexplained absences or difficulty in seeing the recipient to complete necessary redeterminations;
- reluctance to provide needed information about income and/or resources;
- unexplained and continued refusal to have certain pertinent references or relatives contacted; or
- complaints or remarks of other persons.

The worker should be alert to any information that can lead to the identification of a case discrepancy. If such information becomes available, the worker should take the action listed in Section 4605.05.05, Caseworker Responsibilities, then enter a referral to the BV unit on BVBR if appropriate.

The worker is responsible for completing all investigations that can be done from the office: By phone, mail or interview. This includes data matches. Use Subpoena (Form FI0018/State Form 48133) to obtain needed verification when a signed client "Release of Information" is not available or appropriate. If it appears that the investigation cannot be completed in the office, a referral to the Bureau of Investigation is to be made by the worker and sent to the Fraud Referral Coordinator to review, sign and fax to the Bureau.

4610.15.20 Investigation Of Possible Fraud

If the AG is currently eligible, assistance is not to be discontinued solely because an investigation of suspected fraud is being conducted, nor is the worker to discuss an investigation by the Bureau of Investigation with the client.

The Local Office is required to pursue suspected fraud. It is the responsibility of the caseworker to do the initial investigation and then, if appropriate, refer the case to the Bureau of Investigation (B of I). Based on the

caseworker's and the B of I investigator's findings, and if the case meets the Local Prosecutor's criteria, the individual may be referred for prosecution to the County Prosecutor. For Food Stamps and TANF, the individual may be referred for an Administrative Disqualification Hearing (ADH) instead.

The methods used in investigating possible fraud should be adapted to the situation of the AG and the eligibility factors concerned. The investigation must be conducted in such manner that:

the legal rights of the AG are preserved;

the privacy of the home is not invaded without consent;

search and seizure are not committed;

the AG's right to due process of law is protected;

the right to legal counsel is not obstructed; and

confidential information is used only for the administration of assistance.

4610.15.25 Report Of Fraud Investigations and Adjudications

When the investigation is completed, a report of all facts in the case is to be made. If the report reveals no basis for the suspicion of fraudulent activity, such decision is to be entered in the case record. Exoneration of the innocent is as important as prosecution of the guilty. If the report indicates a basis for suspected fraud, the period of time during which it is believed that the AG fraudulently obtained assistance is to be made a part of the record. For Medicaid, this is to be done with the knowledge and approval of the Local County Director or his designee. The Director of the Local Office or his designee is to be informed of the report.

It is important that **all** investigations for **all** programs be entered in the Fraud and Investigation Statewide Tracking System (FIST). Caseworker initial desk investigations should be entered as well as referrals to the Bureau of Investigation. The FIST number must be entered on the referral (FI0013) to the Bureau. Update and add information as changes occur. FIST updates for each month are to be sent to the Central Office, Fraud Tracking Clerk by the 10th of the following month. Counties may request FIST by e-mail from Jeff Drummond, Food Stamp Policy Unit.

All individuals referred for prosecution or an ADH must be reported on the A*djudication* screen in FIST. Reports must be updated as each case progresses through the legal system. The code for a Bureau of Investigation referral for prosecution has been left as "O" for OAG. Since the Bureau continues to investigate and prosecute any cases opened by the OAG pre-2001, it was decided to continue using the "O" when referring to the Bureau of Investigations for investigations and adjudications when the BI sends the case to the prosecutor (Do not recode a BI prosecution case as "B").

4610.15.30 Referral To County Prosecutor

The Bureau of Investigation (B of I) will decide whether to refer for prosecution the cases completed by them. The Fraud Referral Coordinator (FRC), together with the County Director may choose to prepare a desk investigation for prosecution without involving the B of I. The County Prosecutor has the final word concerning the type and number of cases against which criminal charges will be filed or whether criminal charges will be filed at all. Once the criteria is established the Fraud Referral Coordinator should, in most cases, be able to determine the appropriate action upon case file review. The Local Office should have an agreement with the Prosecutor and knowledge of the documents and procedures which the Prosecutor will request. All available evidence must be provided with the referral. Repayment of a claim must never be discussed with the AG pending the outcome of the Criminal Court action therefore; claims intended for prosecution should not be opened until adjudication is completed.

Once the decision has been made to refer the claim(s) for prosecution, 'prosecutor information' must be entered on BVRC. Then change the claim status from 'PD' (pending) to 'RP' (referred for prosecution). When the adjudication process is completed, the results must be entered on BVRC and the claim is opened (established) by changing the status to 'OA" (open awaiting client response).

A specific criminal statute exists for acts of welfare fraud committed September 1, 1984 or after, and is applicable for all programs. There are five separate areas of welfare fraud and abuse listed.

The accused person must knowingly or intentionally:

obtain public relief (or assistance) by impersonation, false statement or other means;

acquire, possess, use, transfer, sell, trade, issue or dispose of public relief or an authorization document used to obtain public relief;

use, transfer, acquire, issue or possess a blank or incomplete authorization document to secure public relief;

counterfeit or alter an authorization document to receive public relief or use, transfer, acquire or possess a counterfeit or altered authorization document; or

conceal information for the purpose of receiving public relief or assistance.

4610.15.40 Referral For Administrative Disqualification Hearing (F, C)

For suspected fraud involving Food Stamps and/or TANF, the Local Office may elect to refer the fraud to the Hearings and Appeals Section. A Form 2235, Request for Administrative Disqualification Hearing, must still be sent to Hearings and Appeals, Room W-392, IGCS, itemizing all evidence to be presented at the Hearing. ICES screen HERQ, Hearings Request/Receipt must also be completed for each Program for which you are requesting an ADH. (See Section 4215.00.00.)

The Local Office has the option of offering the client a waiver of the ADH **before** the request is filed with Hearing and Appeals and they have scheduled a hearing. After the 2235 has been prepared it may be presented to the client along with the "Client Waiver Notice", "Information Concerning Administrative Disqualification Hearing" and "Waiver of Right to an Administrative Disqualification Hearing". If the client wishes to accept the disqualification penalty and give up the right to an ADH he/she must sign the Client Waiver Notice.

For Food Stamps only, when using an ADH to establish the IPV category, the local office shall open the claim when completed, before the ADH, **IF** the AG is currently receiving the benefit. Category type is PPV (Pending Program Violation) and Allotment Reduction should be started immediately.

If possible, while sending the notice of overpayment generated when BV status is changed to "OA", the supervisor may request an Administrative Disqualification Hearing using screen HERQ.

Sending the notice of overpayment and requesting the ADH may be done concurrently so that an IPV hearing may be consolidated with a fair hearing if requested. Should the AG contact the Local Office requesting a fair hearing, the

supervisor is responsible for informing the Hearings and Appeals Section of the request. Refer to Section 4215.00.

If the client is not currently receiving Food Stamps, or if the claim is on TANF benefits, do not open the claim but enter status code 'AH' (referred for ADH) on BVRC. A new report will allow the agency to track all claims awaiting completion of fraud adjudication.

If the ALJ (Administrative Law Judge) sustains the request for the IPV, the supervisor must change the type of claim to IPV before entering the disqualification information on BVRC and BVFV if the claim was already opened. If the claim was in "AH" status, the claim status must be changed to "OA".

4610.20.00 EVIDENCE USED TO SUBSTANTIATE FRAUD

When preparing a case for a court or administrative hearing, evidence is necessary in order to prove the Local Office's allegation of fraud. Evidence can include written records or statements or verbal testimony. Information received through Data Exchange is not verified unless the agency providing the information is the source of the payment. It is necessary to secure verification directly from the employer, bank or other source of the income.

It is also necessary to prove the intent to fraud. Verification that the AG member understood his responsibility for reporting the information in question may be used to substantiate intent. This verification could include:

- the completed Rights and Responsibilities form;
- the signed application;
- previously submitted Change Report forms; or
- recorded and/or verified instances of other changes reported by the AG which could or did affect the benefits received.

An application or Change Report form submitted during the period fraud is suspected which omits the information that resulted in the over issuance may be used to substantiate intent.

Recorded instances which indicate that the AG visited the office during the period fraud is suspected and did not report the change which resulted in over issuance may be used to substantiate intent. These instances might include a record of the dates benefits were issued to the AG, copies of signed Food Stamp receipts, redetermination interviews with applications or CAFs, signed Notice of Rights and

Responsibilities or Personal Responsibility Agreement, or reports of beneficial changes but not the adverse change.

These examples are not all inclusive; other types of evidence of intent may also be used.

4610.25.00 COURT DETERMINATION OF FRAUD

Fraud must be determined by a court of appropriate jurisdiction. This may be through criminal or civil court or an Administrative Disqualification Hearing. An ADH can only be for Food Stamps or TANF, not Medicaid. The court may designate a repayment schedule. This schedule may be in conjunction with probation. If this occurs the judge may order repayment be made through the County Court or probation system. The judge may also order the AG not to receive assistance for a period of time that court will determine. A court ordered disqualification penalty takes precedence over the standard disqualification penalty. If the ordered restitution is less than the claim, unless the court order strictly forbids any further collection after the restitution is paid, the balance should be collected. Court Probation (CP) must be entered on BVCP under "repayment method".

Since June 1999, Small Claims Court can no longer be used to determine fraud but it can be utilized to assist in collection efforts. (See Section 4635.25.00.) If there is a judgement from Small Claims Court, "SC" must be added on BVCP under "repayment method" (see Section 4635.40 for more information).

4610.30.00 OFFICIAL DETERMINATION OF FRAUD (F, C)

Fraud **must** be determined by one of the following:

a court with appropriate criminal jurisdiction, (Note: Small Claims Court does not have appropriate jurisdiction to determine fraud)

a disqualification consent agreement;

an administrative disqualification hearing;

a waiver of administrative hearing.

Only the above circumstances can determine if a person has committed fraud. In all these cases an IPV disqualification must be imposed.

NOTE: The Hearings and Appeals Section will offer a waiver to the accused individual after the Local Office has requested an ADH. The local office may choose to call the

client in and offer a waiver **before** requesting an ADH. If the client signs the waiver, it will not be necessary to schedule an ADH, however, the waiver will still need to be reported as an ADH waiver on the Fraud Investigation State Tracking System (FIST) PC report.

In addition, for TANF only, the incident of alleged fraud must have occurred on or after May 1, 1995, when the regulation allowing TANF ADH IPVs took affect. (f4)

4610.40.00 IPV DISQUALIFICATION (F, C)

An IPV disqualification is a penalty or period of ineligibility imposed on an individual who has been found guilty as a result of a court decision of fraud or who has been found guilty of an IPV through an Administrative Disqualification Hearing decision or signed waiver. Since ICES sends all notices to the AG (assistance group); the individual Notice of Disqualification (F1 2246 R/4 5/02) must be done manually. This form covers both TANF and FS and all various disqualification penalties. It must be mailed within one day of imposing the penalty on BVFV, and a copy put in the claim file.

4610.40.05 Imposing The IPV Disqualification (F, C)

The IPV penalty is imposed after:

The caseworker learns, from accessing the Hearing Decision Screen (HEDE) or off-line that an Administrative Disqualification Hearing has resulted in the finding that an IPV was committed;

The local office receives a waiver signed by the client; or

The local office is notified (off-line) of a civil or criminal court determination that fraud was committed. Both a misdemeanor and a felony are considered fraud.

Note: If the IPV determination took place at an Administrative Disqualification Hearing, the Hearing Request Type field on HEDE will be coded AH. The Hearing Decision field will show an "S" (county sustained) indicating that the Administrative Law Judge found that an IPV had taken place.

To establish the disqualification, the Benefit Recovery Claim Screen (BVRC) must be completed. An IPV claim type requires that a supervisor code "OA" (Open-Awaiting) in the "Status" field. The Benefit Recovery Intentional Program Violators Screen (BVFV) appears after BVRC has been completed. BVFV actually establishes the disqualification,

displaying begin and end dates and allowing for the coding of information on the IPV decision. After BVFV is completed, if the claim amount is zero, the worker returns to BVRC to change the claim status to "closed" (CL). The system will begin the disqualification at the appropriate time.

For Food Stamps, the period of disqualification begins the first month following the month that the Agency received the written notice of the hearing decision, waiver or court judgment, regardless of whether the individual is currently receiving Food Stamps.

For TANF, the period of disqualification may not be imposed on an individual who is not currently in TANF-eligible status. Therefore, if other program sanction periods (such as IMPACT or IV-D) are already in place, they must be served and the individual returned to TANF eligible status before a TANF IPV disqualification period can be established. The begin and end dates do not display unless the individual is currently in a TANF AG and will be disqualified. Otherwise the IPV information is entered and dates remain blank until the individual reapplies. The system will begin the disqualification at the appropriate time (no later than the first day of the second month which follows the date of notice) if the client is currently eligible for TANF. (f5)

The disqualified person’s income continues to be used in the TANF eligibility determination; his needs however, are not taken into consideration in the budgeting. The remaining assistance group member’s eligibility is affected only insofar as the removal of the disqualified person’s needs for the TANF budget reduces the grant amount or causes the assistance group to lose financial eligibility. (f6) For more information see Section 4630.30.00.

The budgeting procedure is identical to that utilized for other sanctioned individuals (outlined in IPPM Section 3450.45.10).

4610.40.10 Food Stamp IPV Disqualification Periods (F)

The length of disqualification for a FS IPV will be will be determined as follows:(f5a)

One year for the first violation;

Two years for the second violation;

Permanently for the third violation;

Two years for a first finding by a court for purchasing a controlled substance with Food Stamps;

Permanently for the second finding by a court for purchasing a controlled substance with Food Stamps;

Ten years for a finding that a fraudulent statement or representation about identity or place of residence was made in order to receive duplicate benefits (there do not have to be benefits issued in order for this rule to apply). Unsuccessful attempts to commit fraud in this manner will be dealt with in the same manner as successful attempts;

Permanently for a conviction of a trafficking offense of $500 occurred in a single transaction or multiple transaction); or

Permanently for the first finding by a court for purchasing firearms, ammunition or explosives with Food Stamps.

Note: A ten year disqualification is entered in ICES on BVFV or BVPI as 97 (months) and a permanent disqualification is entered as 99 (months).

4610.40.15 TANF IPV Disqualification Periods (C)

When the IPV is determined by an ADH or and ADH Waiver:

First occurrence results in a six-month disqualification;

Second occurrence results in a twelve-month disqualification; or

Third occurrence results in permanent TANF ineligibility.

For an individual who is convicted of a misdemeanor:

The first occurrence will result in a twelve month disqualification;

The second occurrence will result in a twelve month disqualification; or

The third occurrence will result in a permanent disqualification. (f5b)

For an individual who is convicted of a felony:

The first occurrence will result in a ten year disqualification;

The second occurrence will result in a ten year disqualification;

The third occurrence will result in a permanent disqualification. (f6b)

Note: A ten year disqualification is entered in ICES on BVFV or BVPI as 97 (months) and a permanent disqualification is entered as 99 (months).

4615.00.00 TIME LIMITS FOR OVER ISSUANCE REFERRALS (F)

For agency error and inadvertent error cases, a benefit recovery (BV) referral will be made and a claim for over payment established when 36 months or less have elapsed between the month the over issuance occurred and the month the agency became aware of the over payment. An AE or IE claim may go back 3 years or to the beginning of the overpayment, whichever is less.

For alleged fraud cases, a BV referral will be made when 72 months or less have elapsed between the month the over issuance occurred and the month the agency became aware of the over payment. An IPV claim must go back 6 years or to the beginning of the over payment, whichever is less. (f7)

4615.05.00 TIME STANDARDS FOR INITIATING RECOVERY (C)

The Local Office must take one of the following actions by the end of the quarter following the quarter in which the overpayment is first identified:

Recover the overpayment in full;

Initiate action to locate and/or recover the overpayment from a former recipient; or

Execute a monthly recoupment from the current recipient's grant. (f2)

4615.10.00 TIME STANDARDS FOR INITIATING RECOVERY (F)

Claims must be established (opened) by the end of the quarter after the quarter in which the claim was discovered. The discovery date is defined differently for AE and IE than it is for IPV claims. For AE, IE, or PPV claims, the discovery date is the date that documentation was received by the agency which verified there was indeed an overpayment. For IPV claims, the discovery date is the date that the agency received information regarding the completion of the adjudication process with a finding of fraud/IPV. (f8)

When entering a referral on BVBR, the "discovery date" is blanked out. BV workers must be sure the discovery date is accurately added before opening a claim. If or when the

discovery date is corrected, a comment should be entered on ICES screen CLSC (using PF2) to inform the reader as to why and when the discovery date was changed. An ICES report tracks the discovery date on all newly opened claims.

> EXAMPLE:
>
> A DENH data match dated 4/9/04 showed a new job for client X. The caseworker worked alerts the next day and sent out a FI0065, Request for Earnings Information, and it was filled out and returned and reached the caseworker on 7/16/04. The 65 showed that the client had been employed full time since April 3, 2004 and was over the gross income limit from April on. The next week the caseworker used the information to calculate the claim, using the discovery date of 7/16/04, and opening the claim as type “PPV". The Administrative Disqualification Hearing was held in October, and on December 3, the caseworker received a copy of the decision, in which the IPV was sustained. The caseworker changed the type to “IPV" and changed the discovery date to 12/3/04, putting a comment on CLSC to explain the change.

A data match on wages or new hire does not mean that the information has been verified, therefore a “match date" is not the discovery date. Exceptions to this statement are matches on DEUI or DECB and the Social Security screens DENB,DEBN and DESX. These data matches are with the agencies that actually dispense the benefits, and therefore no further verification is necessary.

4615.15.00 PENDING CLAIM REFERRAL TIME PRIORITIES (F)

In order to ensure that claims are established by the end of the quarter following the quarter in which they were discovered, pending claims are to be worked from the newest referral to the oldest referral.

A QC pending claim referral remains the first priority and must be completed within 30 days of the assignment. All months effected by the QC discrepancy must be reviewed and included in the claim or restoration. If the claim is truly for only the QC review month, the explanation must be entered on the PF2 "comments" screen. The discovery date will be the date the BV worker received the documentation necessary to complete all months of the claim.

The remaining pending claim referrals will be worked from the most recently received to the oldest, always working referrals on any open Food Stamp cases before those referrals on closed Food Stamp cases. The reason for this

is better chance of collection. For Food Stamps only, allotment reduction should be entered the same day the claim is opened. Once the claim has been "OA"d, the status can be changed without interfering with the generation of the Notice of Overpayment – Demand Letter (BV01).

If the claim referral does not contain enough information to show that an overpayment exists, the referral should be cancelled and a message sent to the referring worker requesting more information/documentation with a new referral.

NOTE: Pending Claim Referral time priorities applies only to Food Stamp claims. However, when an error results in multiple program claims, it is practical to complete all claims at the same time.

4620.00.00 COMPLETING THE BENEFIT RECOVERY REFERRAL

Once it has been determined that an over issuance referral is necessary and that the over issuance occurred within the appropriate time period as listed in the previous section, the eligibility worker is to complete the Benefit Recovery Screen BVBR including the comments screen which is accessed by using the PF2 key. Refer to Section 4605.05.05, Caseworker Responsibility, as to the necessary information which must be entered on the comment screen. If incorrect dates are entered, the BV worker can correct these dates later on BVRC.

If the caseworker is also the BV worker, the worker completes all of BVBR. If the caseworker is not the BV worker, the caseworker completes all but the Referral Assignment portion of BVBR.

4620.05.00 ASSIGNING THE REFERRAL TO THE BENEFIT RECOVERY WORKER

After a BV referral has been made an alert is generated. If a BV worker is to complete benefit recovery, the alert is generated to the BV coordinator. If the caseworker is also the BV worker, the alert is generated to the caseworker's supervisor. It is at this point that the BV coordinator will assign the case to the BV worker. All claim referrals are to be assigned to a worker within fifteen working days of the referral being made.

4620.05.05 Over Issuance Calculation (F)(C)

Once the case has been assigned on BVBR, claims calculation can begin. In order for the BV worker to do the claims calculations, that worker can put the case in Scratchpad. It is important however, to notify the eligibility worker whenever a case is put in Scratchpad. Scratchpad is

activated on screen MNSC by entering start and the case number. Once the case is in Scratchpad the BV worker can begin manual calculations which will then be entered on BVCC.

The BV worker is to complete a budget for each month an over issuance is identified. Calculations to determine over issuances must be in accordance with eligibility requirements and budgetary procedures and allowances in effect at the time of the over issuance (not at the time of discovery and computation). See Section 4620.10.00 for determining the amount of over issuance for Food Stamps and Section 4620.30.00 for determining the amount of over issuance for TANF.

There is a software package available from Central Office that calculates both Food Stamps and TANF utilizing the correct standards and allowances in effect for the months of the claim. This system provides a screen print of the calculations for each month of the claim. Contact the BV Coordinator in Family Resources.

4620.05.05.05 Determining The First Month Of Over Issuance (F, C)

The determination of the first month of over issuance is based upon when the AG had knowledge of the change and the caseworker's requirement to act upon reported information. The first month of the claim will be the first of the month following the 33rd day after the date the AG had knowledge of the change. The reason for this is as follows:

- 10 days for client to report change;
- 10 days for caseworker to act upon change; and
- 13 days for the mailed adverse action notice.

For employment, the date of knowledge is defined as the first day worked.

EXAMPLE:

Client began employment on July 15th and the 33rd day would be August 17th, so the first month of the claim would be September 1.

Exception: If the client withholds information or gives erroneous information at the application or redetermination interview, the claim starts with the beginning of the new certification period, whether or not it is 33 days later.

4620.05.05.10 Determining The First Month Of Over Issuance – Simplified Reporting (F)

The simplified reporting waiver allows for households certified for six months to report income changes ten days after the month in which the change occurs. Because households do not know the income amount in many situations until the end of the month, this gives the household time to determine if a change has occurred. Therefore, if reported by the 10th day of the following month, no error or claim will be involved.

> **EXAMPLE:**
>
> Client gets a raise on July 1 that will take effect the next week. She calculates that the raise will not put her over the 130% FPL. With the raise comes an increase in hours worked, so that at the end of August she adds up her gross pays and she is over the 130%. If she reports this by the 10th of September, there is no error and no claim even though she knew of the raise on July 1 and even if the verification does not arrive in time to make the budget change until after adverse action for October.

A claim will not be established for the reason that the AG failed to report a change that it was not required to report. (See 4610.05.05) However, all information reported by the client must be worked. All data match alerts must be worked. If the information or alert is worked late, there may be an AE claim because the worker failed to act timely – not because the client “failed to report”.

4620.05.10 Total Ineligibility

Failure to meet certain eligibility requirements will render an AG totally ineligible, thus negating the necessity for individual monthly calculations. These eligibility factors are:

- state residency;
- excess resources;
- excess gross income;
- duplicate participation of an AG;
- entire AG made up of ineligible aliens and/or ineligible students or individuals who fail to comply with SSN requirements;
- AG's refusal to provide requested information/verification (use Form 2244) concerning AG composition, income, or resources

If the circumstances involved support a conclusion of IPV, the decision must be made whether to refer the case to the prosecutor, or for an ADH. This decision will be made based on criteria listed in Sections 4610.15.30 through 4610.15.40. If an ADH is selected, the BV worker will request the hearing using HERQ and list all evidence to be presented on the Form 2235, Request for Administrative Disqualification Hearing. An ADH can only be done for TANF and Food Stamps, not for Medicaid.

The entire claim case file will be submitted to the Fraud Referral Coordinator for review and approval prior to the Notice of Over issuance being sent to the AG.

4620.10.00 DETERMINING THE AMOUNT OF OVER ISSUANCE (F)

The following procedures shall be followed in determining the amount of over issuance:

Procedure:

Eligibility factors that require individual monthly budgetary calculations to determine eligibility and allotment amounts will be figured and monthly amounts entered on screens BVCC or BVMC as stated in Section 4620.05.05, Over Issuance Calculation.

If an over issuance was caused by the AG's failure to report income, the worker will not include any newly reported deductions from that income such as dependent care. Do not apply the earned income deduction to that part of any earned income that the household failed to report in a timely manner when this act is the basis for the claim.

Note: Actual participation is required for each month in order for an over issuance to have occurred in that month. If a certified AG did not pick up their stamps, no over issuance occurred. **Regarding EBT accounts, the benefits are considered "issued" when they are entered in the client's account.**

Recalculation by Element:

Household Composition other than ineligible member (including reclassification of AG members to non AG members):

- Add or subtract the individual from the AG.

- Add or subtract resources owned by the individual.

- Add or subtract the income of the individual.

- Add or subtract expenses billed to the individual. Certain deductions, such as shelter, will normally remain as an AG expense even though they were billed to/paid by an individual who leaves the AG.

Household Composition - Ineligible Member due to IMPACT for CWEP sanction or IPV disqualification:

- Subtract the individual from the AG size.

- Retain income, resources, and expenses of disqualified member. Recheck gross/net income limits based on revised AG size.

- Determine the AG totally ineligible if it fails the gross/net income test.

- Determine the corrected allotment if the AG passes the gross/net income tests.

For other ineligible members (SSN, non-compliance and ineligible aliens):

- Subtract the member from AG size. Retain their entire resource amount.

  Recalculate the gross income.

  Recalculate the net income prorating the ineligible member's income/expenses.

  Determine the corrected monthly allotment if the AG passes the gross/net income limits.

Income:

- Include actual TANF benefits received, even if there will be a TANF overpayment also.

- Compute correct actual gross income. Actual unconverted income for the month of claim is used if this income is the reason for the claim. Reported income or other elements do not need to be re-verified or re-calculated using actual amounts.

- Determine if the AG is gross income ineligible and therefore over issued the total allotment.

- Determine correct net income, if the AG is not gross income ineligible. Do not apply the earned income deduction to that part of any earned income that the household failed to report in a timely manner when this act is the basis for the claim. NOTE: Claims calculated in Scratchpad can now be calculated without the 20% disregard.

  The 20% Earned Income Deduction is not allowed on any claim type for over issuance caused by an AG's failure to report earned income timely.

- Determine the corrected allotment if the AG is net income eligible.

Deductions:

- Replace the previously used deduction with the correct figure only if the deduction is part of the reason for the claim. If that is not so, there is no need to re-verify this figure. Keep in mind that an unreported deduction from unreported income is not allowed.

- Recalculate the net income based on the changed deduction. The actual deduction for the month of the claim is used. Deductions paid weekly or biweekly are not converted to a monthly amount.

- Determine if the AG was over the net income limit.

- Calculate the correct allotment if net income eligible.

AGs will be allowed the standard deductions in effect during the over issuance month.

Dependent care and medical expense deductions that were previously verified are to be included in calculating the budget provided that the verification for these is recorded. The BV worker is not required to re-verify all factors pertaining to the household, only the discrepant data that the worker becomes aware of due to the circumstances regarding the claim.

4620.10.05 Determining the Amount of Over Issuance From DWD Data Matches (F)

When unreported earnings are identified by a data match with the Department of Workforce Development (DWD) on ICES DEWX screen, a letter should be sent to the client advising them of the discovery and giving them a 30 day period in which to provide verification of the earnings from the identified source and also telling them that if a response is not

received, the agency will calculate and open a claim using the information available. This '30 day' letter will become a state form on the internet. In the meantime, copies may be obtained from the BV Coordinator in the Food Stamp Policy Unit.

The client is solely responsible for obtaining the wage information. The 10-10-13 rule does not apply in this process.

After 30 days with no response from the client, the agency will calculate the over issuance by dividing the quarterly wage data into three equal parts and multiplying each by 30 percent. This is the over issuance amount for each month, up to the amount of issuance for that month. This method approximates the 30 percent reduction formula upon which Food Stamp allotment amounts are based.

A new code has been added to the reason codes on table TBRC. These reasons are printed in the Notice of Over Issuance/Demand for Repayment Letter (BV01). The new code (916) advises the client of the approximated over issuance and gives the client 90 days to provide the information requested. Always add this code when using this process.

The agency should then open the claim to 'OA' status and ICES will generate the BV01. If the client provides the required verification, the claim will need to be re-calculated and re-opened. If the client does not provide this within 90 days, the established amount becomes final.

4620.10.10 Determining the Amount of Over Issuance in Trafficking-Related Claims (F)

"Trafficking" means the buying or selling of Food Stamps or other benefit instruments for cash or consideration other than eligible food. Claims arising from trafficking-related offenses will be the value of the trafficked benefits as determined by a signed waiver of ADH or an ADH or court decision. If the court or Administrative Law Judge (ALJ) determines there was no trafficking, then the claim will be cancelled.

There is no claim if trafficking was not proved. Therefore, trafficking claims should not be opened before adjudication.

4620.10.15 Claim Thresholds (F)

In order to process claims faster and more efficiently, overpayment referrals on claims for non-recipients are to be cancelled if the claim will be under $125.00. Overpayment referrals on claims for Food Stamp recipients are to be cancelled if the claim will be under $75.00. At any point that the worker can determine that the claim will be under

the threshold, the worker may cancel the claim referral.

The exceptions to the claim referral thresholds are two: QC and IPV. All QC overpayments are to be established. Thresholds are ignored for QC claims. A claim of any amount (even zero) may be referred for an Administrative Disqualification Hearing (ADH) because IPV disqualifications are a deterrent to future fraud attempts. (f10)

4620.15.00 AGENCY AND INADVERTENT ERROR IN SAME MONTH (F, C)

Follow the steps below to determine claims in which both an agency and inadvertent error occur for the same issuance. In the unlikely event that there is also an IPV the same month, the IPV would be done after the IE claim and calculated in the same manner.

Secure the actual calculations for the month of possible over issuance.

Determine the eligibility/allotment after correcting only on the factors which were agency error(s).

Determine the total over issuance caused by agency error.

Use the budget which was just recalculated which contains the corrected agency error information and recalculate that budget using the information which was originally incorrect due to Inadvertent Error (IE) or Intentional Program Violation (IPV).

Compare the allotment recalculated in the first step to the allotment recalculated in the second step. The difference will be the amount of over issuance used to calculate an IE/IPV claim.

NOTE: The total over issuance due to AE, IE or IPV error cannot exceed the actual amount originally issued.

4620.20.00 CATEGORICALLY ELIGIBLE AGs WITH OVER ISSUANCES (F)

AGs cannot be retroactively determined to be not categorically eligible for Food Stamps. However, when it is determined that the entire AG was not eligible for TANF or included as a member of the TANF AG (see Section 2414.10.05) or SSI for a period of time when the AG was receiving Food Stamps as a categorically eligible AG, the worker needs to determine if the reason the AG was ineligible for TANF or SSI is because of inaccurate AG composition or income being budgeted. If the AG received an over issuance during this period because a change in AG composition or income was not

reported or reflected in the budget calculations, a claim based on a change in net income or AG size will be computed based on correct AG size and net income.

4620.25.00 PENDING IPV DETERMINATION (F)

A claim calculation for an AG which contains an AG member believed to be guilty of an IPV may be opened before adjudication if the claim is going to ADH, not court prosecution, and the AG is currently receiving Food Stamps. The only reason to do this is to start the allotment reduction as soon as possible. Claim Error Type on BVRC is PPV, Pending Program Violation. This allows recovery activity to begin before an official determination of Intentional Program Violation (IPV). For most over issuances it is essential to begin recovery efforts as soon as possible. If the overpayment is being sent to Prosecution/Criminal Court, do NOT open the claim.

When claim collection is to be delayed until after the court determination of IPV, the BV worker will compute the claim using IPV guidelines as listed in Section 4620.10.00. The amount of over issuance will be needed for the court action. No overpayment notice is to be sent to the AG prior to an official determination of IPV. To keep the notice from being issued, the worker refrains from entering OA for Open Awaiting Client Response on screen BVRC in the status field. When the claim calculation has been completed and the FRC knows the case will be referred to the prosecutor, the worker should enter "Y" and the date the decision was made to refer on BVRC, on the right hand side of the screen under "Prosecutor Information".

When claims recovery is begun as type PPV pending an ADH, and a determination of IPV is then made, the claim must be changed to claim type IPV and the disqualification information added on BVFV.

4620.30.00 DETERMINING THE AMOUNT OF OVER ISSUANCE (C)

The Local Office is to recover any over issuance identified when:

the AG or any member thereof is ineligible for any payment month; or

a benefit reduction would have occurred had a change of circumstances been appropriately budgeted.

In determining over issuances for past time periods, reflect the actual income and circumstances which existed during that time period.

4620.30.05 Budgeting Improperly Retained Support Payments (C)

If assigned support is not sent to the Indiana Child Support Bureau, that income must be included in the TANF budget to determine the AG's award in addition to the imposition of a noncompliance sanction. All monthly support payments received directly, must be shown as unearned income to the AG in the month of receipt.

4620.30.10 Reducing An Overpayment With Child Support Collections (C)

When child support collections have been made for a month when a TANF over issuance has been calculated, it is necessary to determine whether the support retained by the Child Support Bureau completely reimbursed the TANF grant in that month. If the child support payment fully reimbursed the original TANF grant, no TANF over issuance exists. However, child support payments that partially repay the TANF grant require further consideration as follows:

Child support collections which equal or are less than the corrected TANF grant do not result in a reduction in the TANF over issuance as the support did not fully reimburse the corrected grant.

Child support collections which are greater than the corrected TANF grant require an adjustment in the over issuance calculation. The over issuance is reduced by the amount of surplus support which was left after the corrected grant was reimbursed.

4620.30.10.05 Computation Of The Adjusted Overpayment (C)

Form 2070, Child Support Offset for the Overpayment Calculation, may be used in completing this calculation manually.

Compute the corrected grant amount.

Determine the gross over issuance:

- Total incorrect TANF entitlement;
- subtract the corrected grant amount;
- this equals the gross over issuance.

Determine the amount of surplus child support:

Net child support collection;
subtract corrected TANF grant amount;
this equals surplus child support available.

If this amount is zero or less, no further calculations are necessary.

Determine the adjusted over issuance:

- Gross over issuance;
- subtract surplus child support;
- this equals the adjusted over issuance.

EXAMPLE:

The TANF AG received a grant of $171 in November. It was later determined that the grant amount should have been zero. The November child support collection was $150.

Corrected Grant amount	$ 0
Gross over issuance:	
Incorrect entitlement	$171
Minus the correct grant	- 0
Gross over issuance	$171
Child support collection	$150
Surplus child support:	
Child support	$150
Minus corrected grant	- 0
Surplus child support	$150
Adjusted over issuance:	
Gross over issuance	$171
Minus surplus child support	-150
Adjusted over issuance	$ 21

4620.35.00 DETERMINING THE AMOUNT OF OVERPAYMENT (MED)

The total amount of Medicaid benefits paid during a period in which the AG was ineligible for MA is recoverable from the recipient or his estate. (f4) (For information regarding the filing of a claim against an estate, refer to Section 4650.00.00) Recovery can be pursued even when there is no suspicion of fraud. Medicaid benefits paid in error pending receipt of a hearing decision are to be recovered. (f5)

A recipient who acquires excess resources is totally ineligible. The amount which is recoverable is the total Medicaid expenditures for the month in which the recipient was ineligible.

An overpayment of Medicaid benefits may occur as a result of budgeting an incorrect amount of income; however, consideration of the income may result in the imposition of or increase in spend-down or liability rather than total ineligibility.

The calculation of the Medicaid overpayment is done off-line. However, BVMC is available for the manual calculation of claim amounts when entering more than one month. The issued benefit amounts and the correct benefit amounts should be entered on BVMC. Press PF16 to have the system calculate and display the claim amount. This information is then entered into the system to proceed with the benefit recovery process.

For the individual whose liability should have been higher, the amount to be recovered is the difference between the correct and incorrect liability or the amount of Medicaid expenditures for the month, whichever is less. When entering liability/spend-down situations on BVMC, the order must be reversed. Enter corrected liability/spend-down amount in the "Issued" field and the previous amount in "Correct" benefit field.

For the individual whose spend-down should have been higher, the amount to be recovered is determined as follows:

(a) Subtract the incorrect spend-down from the correct spend-down.
(b) From that difference, subtract the individual's "out of pocket" expenses and his spouse's/parent(s)' out of pocket expenses incurred after the effective date for that month.
(c) The resulting amount or the amount of the Medicaid expenditures for the month, whichever is less, is the amount to be recovered.

When requesting the claim history of all Medicaid expenditures the Local Office should use State Form 6533 OFE 1042 (revised 6-97) and follow the procedures below:

For medical expenditures involving recipient Third Party Liability (TPL), requests should be addressed to EDS, third party liability, PO Box 68762, Indianapolis, IN 46268-8762.

Requests for Medicaid expenditures involving recipient fraud, estate recovery and all other Medicaid expenditure requests involving reimbursement should be addressed to the Office of Medicaid Policy and Planning (OMPP) Attn: Estate Recovery, 402 W. Washington, Room W-382 MS 07, Indianapolis, IN 46204 (FAX 317-232-7382).

EXAMPLE 1:

The Local Office verified that as of April the AG had $500 in excess resources, which had not been reported. As of May 1st, the AG's resources were within the resource limitation. Medicaid expenditures for April were verified to be $750. The amount to be recovered is $750.

EXAMPLE 2:

Based on the AG's reported income, he had a spend-down of $34. In April he began receiving rental income. This was discovered in July and a $100 increase in his spend-down was budgeted effective August 1st. Recovery is for the months of May through July.

Incorrect spend-down amount	$ 34
Correct spend-down amount	134
Difference	$100

	Effective Date	Expenses After Effective Date	Medicaid Expenditures
May	5/10	5/11 - $10 - wife 5/20 - 25 - recip.pd. $35	$150
June	6/5	6/10 - $40 - wife	$ 50
July	7/10	None	$200

For May:
$100 (difference between correct and incorrect spend-down)
- 35 (recipient's "out of pocket" expenses and his wife's expenses)
$ 65 (recovery amount)

For June:
$100 (difference between correct and incorrect spend-down)
- 40 (wife's expenses)
$ 60 (recovery amount)

For July:
$100 (difference between correct and incorrect spend-down)
The recovery amount is $100

The total recovery amount is $215.

4625.00.00 PERSONS RESPONSIBLE FOR REPAYMENT

The individuals who are responsible for repayment of an over issuance vary by program. The following sections discuss these differences.

4625.05.00 PERSONS RESPONSIBLE FOR REPAYMENT (F)

All adult AG members, 18 years or older, who were adult members of the AG at the time the over issuance occurred will be jointly and individually liable for the value of any over issuance of benefits. If the claim is because an adult was not in the household, they are not liable. Always check BVLI after opening a claim and delete or add as necessary.

In addition, the sponsor of an alien household member is liable if the sponsor is at fault. Also liable is a person connected to the household, such as an authorized representative, who actually traffics or other wise causes an overpayment or trafficking. (f11)

If there were no AG members age 18 or older at the time the over issuance occurred, the payee will be held liable. If an AG member under age 18 is found guilty of an IPV, that member will also be held liable for the associated claim. In order to add a liable individual to the claim, use screen BVAP.

The BV unit may pursue recovery action against any AG which contains a member who was an adult member of the original AG at the time the over issuance occurred.

The BV unit will pursue recovery action against an AG which contained an AG member found guilty of committing an IPV and which received the over issuance for which the claim was established.

If a change in AG membership occurs, the BV unit will pursue recovery action against all current AGs containing at least one adult who was in the AG when the overpayment occurred.

Occasionally all liable individuals move to other Food Stamp households or become non-recipients while the original AG continues with a non-liable individual as head. ICES can be corrected by using screen BVAA with the liable individual's RID, so that the claim follows the liable individual rather than the original AG sequence.

4625.10.00 PERSONS RESPONSIBLE FOR REPAYMENT (C)

There are two categories of claims, and they must be treated differently. The first category includes claims that occurred prior to 1996 and the second category is for claims that have occurred after 1996 or PRWORA.

ADC claims occurred for months before the Personal

Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) which is date August 22, 1996.

For all ADCR and ADCI claims from before PRWORA, **all** members of the AG are liable individuals. To recover an overpayment to an ADC AG, seek recovery from the caretaker relative. Once the caretaker relative is located, the responsibility of the other members of the overpaid AG is discharged. (f12) Therefore, the other members (children at the time of the claim) should be deleted from BVLI. They are no longer liable individuals. If the caretaker relative is deceased or bankrupt, they are considered to be located and the claim should be terminated as 'TD' or 'TB'.

NOTE: The caretaker relative is considered a member of the AG even while sanctioned. If in doubt, check AEACC. After establishing a claim, always check BVLI to make sure it accurately reflects the situation at the time of the overpayment. Use screen BVAP in order to add a liable individual to the claim.

For TANF claims (claims from months after PRWORA), all adult AG members, 18 years or older, who were adult members of the AG at the time the over issuance occurred will be jointly and individually liable for the value of any over issuance of benefits.

If there were no AG members age 18 or older at the time the over issuance occurred, the payee will be held liable. If an AG member under age 18 is found guilty of an IPV, that member will also be held liable for the associated claim.

For TANF and ADCU claims, all children at the time of the overpayment can be deleted from the claim as the cases become known to BV workers. Deletions must be done manually until ICES is reprogrammed. ADCU has always been a state program and so is not subject to the same regulations as ADCR/ADCI.

4625.15.00 RESPONSIBILITY FOR REPAYMENT IN ALIEN/SPONSOR CASES (F, C)

Any individual sponsor of an alien, and the alien, will be jointly and individually liable for any over issuance made to the alien during the three years after the alien's entry into the United States due to the sponsor's failure to provide correct information. (f13)

For ADCI, ADCU and ADCR, if the sponsor had good cause, he will not be held liable for the over issuance and recovery will not be made from him. (f14) Good cause for the sponsor's failure to provide correct information regarding his income and resources is limited to the legal

incompetence of the sponsor at the time the information was provided to the Local Office. (f15)

For Food Stamps, if the alien's sponsor had good cause or was without fault for supplying the incorrect information, the alien's unit shall be solely liable for repayment of the over issuance.

4625.20.00 (RESERVED)

4625.25.00 OVER ISSUANCES AGAINST CWEP PARTICIPANTS (F)

When an over issuance occurs for an AG which has ongoing CWEP involvement, the Local Office will calculate a claim and the subsequent month's work requirement will be reduced by the number of additional hours spent in CWEP the month the claim occurred. The number of hours worked in excess will be calculated by dividing the over issued amount by the federal minimum wage and dropping the remainder.

When an over issuance occurs and the AG is **no longer participating** in CWEP, a claim would be established. If the over issuance is the result of an inadvertent household error or an agency error, a claim would be calculated in the amount of the over issuance minus an amount equivalent to the additional hours spent in CWEP. To determine the amount of the claim, use the formula below:

> amount of over issuance - (number of hours worked in excess of requirement x federal minimum wage) = amount of claim

If the over issuance is the result of an IPV, no credit is given for the additional number of hours spent in CWEP. The claim would be established in the entire amount of the over issuance.

4625.30.00 OVER ISSUANCES AGAINST DRUG/ALCOHOLIC TREATMENT CENTERS (F)

The drug/alcoholic treatment center is "strictly liable for all losses or misuse of food stamp benefits held on behalf of residents and for all over issuances which occur while the individuals are residents of the treatment center". (f16) This means that individual claims against center residents cannot be filed and collection action cannot be taken against the resident. The name of the resident shall be retained, however, for audit/review purposes.

If it is determined that a drug/alcoholic rehabilitation center has misused the food stamp benefits in its possession, the Central Office will notify the Local Office and request that a claim be prepared.

4625.35.00 OVER ISSUANCES AGAINST GROUP LIVING ARRANGEMENT PERSONS (F)

Individuals in a group living arrangement who apply for benefits on their own behalf are solely responsible should an over issuance occur.

If a group living arrangement is designated as the authorized representative and applies for benefits on behalf of an individual, it will be solely responsible should an over issuance occur.

4627.00.00 CANCELING A CLAIM

A claim which was entered in error or must be canceled based on a hearing decision may be canceled on BVRC by changing the status to "CA" and entering the reason code from table TBRC.

A claim may also be canceled on BVCP by entering "Y" for the field "cancel claim?" and entering the reason code.

If the claim is to be canceled, but the payments are not to be refunded; the BV worker should access BVRC and change the status to “TR” (terminate-other) rather than cancel.

When a claim is canceled by entering a "Y" in the cancel claim field and payments are not backed out first, the reason code must be 914. The system will generate an auxiliary for any payments which had been made against the claim. The supervisor will receive an alert to authorize the auxiliary.

4630.00.00 INITIATING COLLECTION ACTION

Collection activity will begin when the BV worker changes the status code on screen BVRC to OA, Open Awaiting Client Response. This will generate the demand notice (BV01) to the payee of the AG for repayment of the claim.

Claims against an AG with multiple claims will be collected in chronological sequence, depending on the type. When a collection or allotment reduction is received, the payment will be posted in the following order; the oldest IPV will be paid in full first, then the next oldest, until all IPV claims are paid in full. Then IE claims will be paid from the oldest to the newest, and lastly, AE claims in the same order.

The maximum amount which can be recouped involuntarily in a month is contained in Sections 4635.10.10 (F) and 4635.10.15 (C).

4630.05.00 RECIPIENT NOTIFICATION OF OVER ISSUANCE (F)

Collection activity on any claim, regardless of type, begins with a notification to the AG. The notice (BV01) contains:

a statement that a claim due to an over issuance of Food Stamp benefits exists;

the amount of the over issuance;

the reason for the claim;

the name(s) of the liable individuals(s);

the AG's right to a fair hearing;

a demand for repayment; and

a statement that allotment reduction is mandatory while any liable individual is receiving Food Stamps; and

the available methods of repayment. (f17)

Allotment reduction should be entered on BVCP immediately after opening the claim. This will not interfere with the BV01 being generated by ICES.

IPV claims may require preliminary steps before notification of the AG. See Section 4630.10.00 for more detailed information.

4630.10.00 OFFICIAL DETERMINATION OF IPV CATEGORY (F, C)

The Local Office will receive notification that the individual has been found guilty of IPV by one of the following methods:

The Administrative Law Judge decision granting the Local Office's request for disqualification;

A copy of the Waiver of an ADH; (For information on the county option of offering the waiver before scheduling an ADH, see Section 4610.15.40.)

A court document which either finds the individual guilty of fraud or finds that the individual must repay an over issuance which was caused by the individual's failure to provide true and accurate information; or

A judicial disqualification consent agreement. A judicial consent agreement is similar to a waiver of an ADH, only it is signed prior to, and in place of, the court appearance.

Once the official administrative or judicial decision is received, the Local Office must send the AG a Notice of

Disqualification within one working day. A Manual Notice of Disqualification, Form 2246, must be sent to the individual regardless of that individuals current participation status. Keep a copy in the claim section.

Collection action as an IPV claim is to be implemented the month after the Notice of Disqualification is received by the AG. If the claim error type of the related claim is PPV, it must be changed to IPV.

Screen BVFV must be completed on the individual found guilty of IPV. This screen is used for State and Federal tracking of IPV disqualifications. Once this screen is completed ICES can identify the individual and impose the disqualification regardless of the county in which the individual ultimately applies.

Food Stamp disqualification data from BVFV is electronically relayed to Disqualified Recipient Subsystem (DRS). DRS then makes the data available to every State. This will insure that when an individual with a Food Stamp IPV disqualification from one State applies in another State the disqualification will be imposed on that person. The County Office is to maintain a copy of the Notice of Disqualification and the instrument, either the ADH decision, judicial review, waiver of an ADH or Disqualification Consent Agreement. No IPV disqualification can take place if these documents are not present in the disqualifying county. Copies of these documents must be provided to other states/counties upon request.

If the request for disqualification is denied or the individual is found not guilty in criminal court collection activity will continue based on the IE category requirements. Change the type of claim to IE.

4630.10.05 Collection Of IPV Claim Pending ADH/Waiver (F)

Pending an official administrative determination of IPV, Food Stamp cases referred for ADH which involve an over issuance will be categorized as PPV, Pending Program Violation, on BVRC and collected as if they were IE claims. When the status is changed to OA, (Open Awaiting Client Response), on BVRC, ICES will generate the notice of over issuance to the AG and the recoupment should be initiated the same day. The only reason to open a claim as PPV is to initiate allotment reduction as soon as possible. Once a determination of fraud is received, the claim error type is changed to IPV.

4630.10.10 Beginning Collection Upon Determination of Criminal/Civil Fraud (F, C)

Collection action is not initiated pending the outcome of criminal or civil action. The Fraud Referral Coordinator may establish a pending further disposition (referral to prosecutor) file. Claim status should be changed to “RP” (referred for prosecution) when the prosecution referral and date is entered on BVRC.

When fraud has been determined by a court of appropriate jurisdiction, screen BVRC is to be updated by entering prosecutor information in results/date and changing the status to 'OA'. This will cause a notice of overpayment to be generated. Screen BVFV is then completed which generates an alert to the caseworker to run eligibility determination/benefit calculation (to remove the disqualified individual) if an active case exists. Disqualification periods are listed in Section 4610.40.10 for Food Stamps and in Section 4610.40.15 for TANF.

A manual notice (FI2246) must also be sent informing the AG of the name of the individual who has been disqualified and the reason for his removal because system generated notices do not contain individual information. The reduction of benefits is appealable; the removal of the disqualified individual is not.

4630.15.00 MONITORING RESPONSES TO NOTICES (F)

The purpose of monitoring an AG response or lack of response to the notice of over issuance is to assure adequate follow-up on financial recovery activities.

The Notice of Overpayment (BV01) requires for IPV claims that an AG select a method of repaying the claim within 10 days of the notice. For IE claims, AGs must respond within 20 days. For AE claims, the limit is 30 days. Mandatory allotment reduction will be imposed on cases currently certified. These will be system entered for Food Stamps.

For non-recipients, either no response to the notice of over issuance will be received or responses will fall into one of the three categories listed below:

- Mail is returned as undeliverable;

- A partial payment or a repayment in full is returned; or

- A request for a fair hearing is received.

  NOTE: If an ADH was requested, send a memo noting this to the Central Office Hearings Section with the request for fair hearing so that the hearings can be consolidated.

The BV worker is responsible for monitoring these responses and entering the appropriate repayment method on BVCP. Update BVCP with the amount and type of payment chosen. If the client requests a Repayment Agreement, send it (form FI0047, for all three programs). The Repayment Agreement states that acceptable monthly payments will be $50 or 3% of the original claim amount, whichever is greater. Emphasize that the 'agreement' means nothing without the 'repayment'.

The **mandatory** allotment reduction will begin with the allotment after the next recurring run following the entry of "RC" on BVRC. No further notice of allotment reduction will be sent.

4630.20.00 RECIPIENT NOTIFICATION OF OVER ISSUANCE (C)

After determining the amount of over issuance, the Local Office must notify the AG of the over issuance. There are two TANF versions of the Notice of Overpayment (BV01). One is sent to current TANF recipients and the other is sent to individuals whose TANF is closed.

By the use of this notice, the AG (or former AG) is given the opportunity to indicate a method and amount of voluntary repayment.

Thirty days are to be allowed for the completion and return of the form.

If a current AG fails to return the form, the Local Office is to initiate recovery by recoupment wherever possible.

If a former AG fails to return the form, the Local Office may initiate legal action.

4630.20.05 Repayment Negotiation (C)

If the Local Office and a current AG cannot reach an agreement on a repayment schedule or the AG fails to sign a repayment agreement, the Local Office is to begin mandatory recovery procedures. Timely notice must include the reason for the mandatory recoupment.

The guidelines for an acceptable repayment schedule are:

a minimum monthly payment of $50; or

a monthly payment of 3% of the original claim amount (that would allow for complete repayment within three years), whichever is greater.

If the Local Office is unable to negotiate a repayment agreement with an AG who is no longer a recipient, appropriate action under state law is to be taken. Securing a judgment through the Small Claims Court, for example, may be effective in recovering an over issuance of TANF. Information regarding proper procedures may be obtained from the Small Claims Court Clerk or the Local Office attorney.

4630.20.05.05 Action Taken When Payor Defaults (C)

Default occurs when an AG fails to perform as he has agreed under the repayment agreement.

Active Cases:

When an individual or a current AG defaults on the repayment agreement, the Local Office is to initiate mandatory recoupment. Timely notice must include the reason for initiating recoupment.

Inactive Cases:

When an individual or an AG who is not currently active defaults on the repayment agreement, the Local Office may take legal action. Legal action includes a judgment through Small Claims Court. Information regarding such action may be secured from the Local Office attorney or the Clerk of the Small Claims Court.

4630.25.00 NOTIFICATION OF MEDICAID OVER ISSUANCE (MED)

After the benefit recovery referral has been investigated and established as a claim, code OA should be entered in the status field of BVRC to open the claim. When the code is entered the system automatically generates a notice of Medicaid over issuance (BVO1). The notice lists the amount of the overpayment, available repayment methods and appeal rights, and notifies the AG of the due date for response.

4630.30.00 TANF IPV AND BUDGETING PROCEDURES (C)

A mandatory TANF assistance group member who is under IPV disqualification acquires the status of non-participating assistance group member. This means that although his income will be counted in the budget calculation, he will not participate as a recipient of the benefit. (His needs will not be considered in the financial eligibility determination nor will he receive any program benefit.) The disqualified person's income is budgeted as deemed income in

determining the participating assistance group members' continuing TANF eligibility. The budgeting procedure is identical to that utilized for other sanctioned assistance group members (outlined in IPPM, Section 3450.45.10). The following income decisions are not allowed:

A deduction from his gross income to meet his needs;

A deduction from his gross income to meet the needs of his non-recipient dependents;

The disregard from his income of IMPACT payments and reimbursements;

If he is a student/dependent child, the 6-month disregard of his earnings; and

The allowable deductions from the disqualified person's earned income are:

The $90 work disregard;

The $30 + 1/3 and the $30 disregards; and

The disregard of out-of-pocket dependent care costs.

An IPV disqualification does not affect a caretaker relative's eligibility for a child care referral.

4635.00.00 RECOVERY METHODS

Recovery of amounts of over issuance will be made by one or more of the following methods:

Lump sum and/or installment payments;

benefit reduction; (TANF and FS)

offset of lost benefits (restorations); (FS and TANF) (f18)

child support credit (TANF only);

interception of lottery winnings;

Federal and/or State tax refund interceptions; or

a combination of the above.

The BV worker must notify the overpaid AG of the amount and cause of over issuance as well as the various repayment methods available. This is done when opening the claim by putting it in 'OA' status on BVRC. ICES then generates the BV01, Notice of Overpayment. For Food Stamps the BV worker

shall initiate allotment reduction immediately, when possible. For TANF, the BV worker must allow a minimum of 30 days for the AG to respond prior to initiating recovery activity.

Sections 4635.05.00 through 4635.10.30 describe methods of repayment.

4635.05.00 LUMP SUM AND INSTALLMENT PAYMENTS

AGs will be given the option of repaying an over issuance either in a lump sum or in regular installments. This includes former AGs who are under court order to repay, as long as the order does not require repayment in a specific manner.

The BV unit will negotiate a payment schedule with the AG and accept regular installments for repayment of any amounts of the over issuance not repaid through a lump sum payment. Any payment will be accepted and credited to the claim, but unless the repayment plan is acceptable, it will not prevent the claim from being delinquent. Payments are due by the 10th of each month. If the minimum acceptable payment is not made by that date, the claim is delinquent and will remain so until the client makes all back payments or the Local Office and the client agree on a new Repayment Agreement. When a Food Stamp claim is delinquent for 6 months, federal taxes and other federal payments can be intercepted. See Treasury Offset Program (TOP) section 4635.40.00.

If the client has both a TANF and/or a Medicaid and a Food Stamp overpayment and does not specify to which claim a repayment should be applied, the payment is to be divided equally between each program. (f18a)

Minimum acceptable payments will repay any claim within three years. For both TANF and Food Stamps, the amount of acceptable monthly repayment is $50 or 3% of the original overpayment, whichever is greater.

Screen BVPC records lump sum and installment payments made by the individual against an over issuance claim. When the claim is paid in full, the system will automatically close the claim and send an alert to the worker. All payments can be seen on screen BVTH. Through screen BVTR, the BV Coordinator can reverse any payment that has already been posted. For example, if an incorrect payment amount was entered by the Accounting Section, payment reversals entered on BVTR will automatically debit claim payments and adjust the claim balance.

4635.05.05 EBT Voluntary Repayments (F, C)

Voluntary repayments of over issued benefits can be deducted

from benefit accounts on the EBT Administrative Terminal (AT). The client must provide a written or verbal statement approving the repayment and the EBT Coordinator or their designee will enter the repayment amount into the AT and Debit the Food Stamp or TANF account. The client must be given or sent a receipt within 10 days. (f19) For Food Stamps, use FNS 135, Affidavit of Return or Exchange of Food Coupons. For TANF, use a note on agency stationery acknowledging the return. The county must post this on the claim in ICES on BVPC using payment code "EB", (EBT transaction).

In cases where the over issuance claim has not yet been established (opened) the return transaction can be recorded on ICES screen SFRF by the county BV Coordinator. This will then show on IQFS or IQCH that the benefits were returned and a claim will not be necessary. It is important that one of these two screens (SFRF or BVPC) show all "repayments" listed on the Monthly Administrative Transaction Detail Report (ARADMTM on EBT Cognos reports).

4635.10.00 BENEFIT REDUCTION (F, C)

Benefit reduction is used to recover over issuance from active AGs.

4635.10.05 Benefit Reduction (F)

ICES will determine the maximum amount of the recoupment and alert the BV worker that a repayment method has not been chosen. The BV worker must enter 'RC' in the repayment method field on BVCP. Then the caseworker will receive an alert to run AEABC for the system to begin benefit reduction the next recurring month. If a non-recipient again receives Food Stamps, ICES will generate the 'RC' and record the new case/category/sequence on BVCP if necessary. This occurs at Mass Change and is triggered by authorization of the Food Stamps. The case worker will then receive an alert to run AEABC.

The amount of the monthly recoupment will change if the AG's allotment changes. ICES will automatically adjust the recoupment amount when the allotment changes.

The $10 allotment minimum benefit for a one or two person AG is not applicable when benefit reduction is applied.

4635.10.10 Amount To Be Recovered In Benefit Reduction (F)

The amount of Food Stamps to be recovered each month through benefit reduction will be determined using the following methods:

For non-fraud (AE, IE and PPV) claims, the amount of Food Stamps recovered each month will be 10% of the AG's monthly allotment or $10 per month, whichever is greater.

For cases in which a fraud determination has been made, the amount will be 20% of the AG's entitlement (which is computed by the system and is based on what the benefit would be with the disqualified individual included in the household) or $20, whichever is greater. (f20)

4635.10.15 Benefit Reduction (C)

Benefit reduction may be used to recover over issuances from current AGs. This may be a voluntary arrangement. In some situations it is a mandatory process. ICES will alert the BV worker to initiate benefit reduction. This is done by adding 'RC' on BVCP. If a liable individual is receiving TANF in a different AG, the new case/category/sequence can also be added on BVCP. All categories of TANF may be recouped from each other.

The BV worker will request the caseworker to rerun ED/BC in order to start the benefit reduction, and the AG will be given at least 13 days advance notice of the benefit reduction.

When the amount of the TANF payment for a month prior to any recoupment is $10 or more but recoupment reduces the amount of the TANF payment to under $10, a TANF benefit is to be issued for the under $10 amount.

If the recoupable amount exceeds the TANF grant, the entire grant must be recouped. If, through recoupment, the amount payable to the TANF AG is reduced to zero, members of the TANF AG are still considered TANF recipients. (f21) (Refer to Section 4635.10.20, Amount to be Recovered in Benefit Reduction (C))

4635.10.20 Amount To Be Recovered In Benefit Reduction (C)

If recoupment is made from the TANF grant, the AG must retain from a combination of the assistance payment, liquid resources, and gross income, 90% of the amount a family of the same composition with no income would receive in TANF benefits. (f22)

Prior to initiating recoupment procedures, the caseworker should ascertain whether the Child Support Bureau has already repaid all or part of the TANF grant for the month in question.

4635.10.20.05 Computation Of The Amount Of Recoupable Income (C)

Computing the amount of recoupable income an AG has is a six step procedure:

Step 1: Compute the amount of the over issuance by comparing the corrected trial budget to the original TANF budget for the month the over issuance occurred. The difference between the correct trial budget and the TANF budget for the month in which the over issuance occurred is the amount of over issuance.

Step 2: Determine the amount the family is to retain each month from all sources:

a) Total adjusted needs;
b) Compute TANF grant without counting income;
c) Multiply the above figure by .90;
d) This equals the amount to be retained.

Step 3: Determine the amount of the TANF grant before recoupment:

a) Total adjusted needs;
b) Subtract countable income;
c) This equals the TANF grant.

Step 4: Determine the total income:

a) TANF grant from Step 3;
b) Add gross income;
c) Add liquid resources;
d) This equals the total income.

Step 5: Determine the monthly income available for recoupment:

a) Total available income from Step 4;
b) Subtract amount to be retained from Step 2.

Step 6: Determine the amount of grant to which the family is entitled:

a) TANF grant from Step 3;
b) Subtract income available for recoupment Step 5 from Step 3.

The system will alert a worker at the time of reapplication when there is an outstanding claim balance. It will also calculate the monthly recoupment amount.

EXAMPLE 1

A mother received unemployment compensation benefits of $120.00 per month for 2 months prior to reporting the income. She started receiving benefits on 1-10 and the reduction would have been budgeted for February. For February and March she was overpaid $120.00 per month, for a total of $240.00. She failed to respond to a notice of overpayment and failed to sign a repayment agreement, so a mandatory recoupment was initiated.

(1) Amount of overpayment $240.00
(2) Amount to be retained
    (a) Adjusted needs $346.50
    (b) Grant without income $346.00
    (c) Grant x .90 = $311.40
(3) Grant before recoupment
    (a) Adjusted needs $346.50
    (b) Income -$120.00
    (c) TANF grant $226.00
(4) Income
    (a) TANF grant $226.00
    (b) Add income of +$120.00
    (c) Add liquid resources of +$0
    (d) Total $346.00
(5) Income available for recoupment
    (a) Income $346.00
    (b) Subtract amount to be retained of -$311.40
    (c) Amount available $34.60
(6) Amount of grant entitled to
    (a) TANF grant $226.00
    (b) Amount to be recouped -$34.00
    (c) Current grant entitlement $192.00

If no other changes occur, $34.00 would be recouped from the TANF grant for 7 months. In the 8th month the remaining $2.00 would be recouped.

If the recoupable amount exceeds the TANF grant, the entire grant must be recouped. If, through recoupment, the amount payable to the TANF assistance group is reduced to zero, members of the AG are still considered TANF recipients.

EXAMPLE 2

For one month, a TANF unit had resources totaling $1,300.00, making them totally ineligible. The TANF payment was $288.00. The unit now has $700.00 savings and is otherwise eligible.

(1) Amount of overpayment $288.00
(2) Amount to be retained
    (a) Adjusted needs $288.00
    (b) Grant without income $288.00
    (c) Grant x .90 = $259.20
(3) Grant before recoupment
    (a) Adjusted needs $288.00
    (b) Income -$0
    (c) TANF grant $288.00
(4) Income
    (a) TANF grant $288.00
    (b) Income +$0
    (c) Liquid resources +$700.00
    (d) Total $988.00
(5) Income available for recoupment
    (a) Income $988.00
    (b) Amount to be retained -$259.20
    (c) Amount available $728.00
(6) Amount of grant entitled to
    (a) TANF grant $288.00
    (b) Amount available $728.00
    (c) New grant $0

The entire TANF grant would be recouped for one month, and the case would remain at MA only for that month.

The monthly amount of recoupment is subject to change. If income or liquid resources fluctuate, the caseworker must recompute to determine the amount of money available for recoupment. Grant reductions due to recoupment must receive timely and adequate notice.

When a former AG with an outstanding over issuance reapplies and is found to be eligible, the Local Office must recover the over issuance. If recoupment is necessary, current income, liquid resources, and the TANF payment are to be used to determine the monthly recoupment amount.

4635.15.00 OFFSET OF OVER ISSUANCE (F, C)

An under issuance results when an AG receives fewer benefits than it should receive in a month.

For the current month, the restoration must be done by Aux. For previous months, the restoration must be done by the BV

under issuance system, starting with screen BVUI and completing on screen BVUO. Restorations and Auxiliaries must be completed by the caseworker, never referred to the BV section for completion.

Federal regulations stipulate that in the event a claim has been established against a household, any benefits to be restored due to an under issuance to the AG at a later date can be offset against the claim amount. If the amount of benefits to be restored exceeds the claim amount for an over issuance, the remaining balance will be restored to the AG and the claim will be satisfied. In any case, ICES generates a notice to the household if the BV under issuance system is utilized. If the restoration is done by ordinary auxiliary, neither offset nor notice will be generated.

For TANF, the Local Office is required to restore benefits to an AG that was under issued benefits. (f23)

For Food Stamps, the Local Office is to restore benefits to an AG that was under issued benefits only when the under issuance was the result of an agency error or an administrative disqualification which was later reversed. Restoration must not go back further than 12 months from the time the agency knew or was told of the under issuance (f24)

EXCEPTION: Retroactive initial benefits are not to be offset against outstanding claims.

For TANF, retroactive corrective payments are not to be considered as income or as a resource to the AG in the month of receipt or the following month. (f25)

A referral to the BV unit for the determination of possible over issuance does not constitute an outstanding claim. The restoration of benefits to a household must not be delayed on the basis of a referral to BV.

4635.20.00 COMMUNITY SERVICE CREDIT HOURS (F)

AGs who have been court ordered to complete community service hours as part of their restitution may have the amount of their over issuance reduced by the dollar value of the service they perform. Each hour is assumed to be worth federal minimum wage unless specified otherwise by the court. When all hours ordered have been completed, documentation must be received by the County Prosecuting Attorney's office prior to adjusting the over issuance amount.

4635.25.00 CIVIL ACTION

All steps necessary to institute civil action are taken when the BV unit determines that such action is required to

recover over issuances from former AGs. Action can be taken through the Local Office or Staff Attorney if he/she determines it is cost effective to obtain a judgement in Small Claims Court.

If a case is returned indicating that civil action cannot be taken against an AG, the BV unit will notify the referring caseworker that there is an unpaid over issuance which cannot be collected at this time. If the former AGs receive Food Stamp or TANF benefits at a later date, appropriate recoupment action must be taken.

4635.30.00 VOLUNTARY REPAYMENT/CIVIL RECOVERY (MED)

After determining that a Medicaid overpayment has occurred and repayment is appropriate, the Local Office is to discuss with the AG the reason recovery is necessary and whether or not he will voluntarily make repayment. If the AG is willing to repay, he must sign a repayment agreement.

Cases are to be referred to Small Claims Court when AGs refuse to sign the repayment agreement or failed to make repayment within the specified period of time. The Local Office must present to the judge all necessary evidence, including the legal basis, substantiating that benefits were paid incorrectly in behalf of the individual. Additionally, the Local Office must present documentation showing potential sources from which recovery can be made. Recovery cannot be made from SSI benefits. (f26) However, Small Claims Court can still issue a judgment if the AG has no available income or assets or his MA case has been discontinued.

When the Local Office receives a favorable judgment in a Small Claims Court, the judgment is to then be entered on the Circuit Court docket as a permanent court record since this is not done by a Small Claims Court. Through this recording an individual can be pursued on the judgment through a lien on real property. (f27)

The attorney for the Local Office is to be consulted for specific information and/or assistance regarding Small Claims Court procedures and other legal matters which may arise when pursuing recovery.

4635.35.00 HEARING REQUESTED ON OVER ISSUANCE

When an AG requests a fair hearing in written form <u>or verbally</u> for the FS AG, regarding the circumstances of an over issuance, the amount of over issuance, or the repayment plan established by the BV unit, the Request for Hearing Screen HERQ must be completed. When the individual's request is in writing, a copy must be sent to Division of

Family and Children, Hearings and Appeals Section, 402 West Washington Street, Room W-391, Indianapolis, IN 46204.

For TANF only: When an AG requests a hearing in response to the notice regarding the amount of repayment, the caseworker is responsible for submitting the request for hearing to Hearings And Appeals Section. For Food Stamps and TANF, if the AG requests a hearing within 10 days from the date of the Notice of Case Action, the benefit reduction will be removed and the previous benefit continued pending the hearing. When the final hearing decision is received, repayment will begin the following month in the amount specified by the hearing decision.

4635.40.00 TREASURY OFFSET PROGRAM (TOP) (F)

TOP is the new name for Treasury Offset Program (TOP). In addition to tax refunds, TOP can intercept portions of Federal salaries and future collections from RSDI and other Federal payments.

Persons who do not currently receive Food Stamps but have a delinquent Food Stamp claim in excess of $25.00, have not responded to the Notice of Overpayment (BV01) and have not made a payment in the last 180 days will be selected for the Treasury Offset Program (TOP). TOP will intercept an individual's Federal tax refund as well as other Federal Treasury payments in order to recoup any over issued Food Stamp benefits that have not been repaid timely.

In addition, claims certified by ICES for TOP must be under 10 years old UNLESS there is a judgement. This is why it is important that information on judgements be entered on BVCP under "repayment method". Enter "SC" for Small Claims Court or "CP" for Court Prosecution.

A 60 Day Demand Letter will be sent by the Financial Enhancement Section to the former recipients when their delinquent Food Stamp claim has been accepted by TOP. The letter will inform them of the amount owed, advise them of their right to review the claim at the local office and instruct them where to send payments. A separate 60 day notice will be sent for each claim. ICES screen BVCP shows whether a 60-day letter was sent. Refunds intercepted by TOP will be electronically posted in ICES. If the Financial Management Section receives voluntary payments that are made to avoid offset, they will be electronically posted also.

4635.40.05 Local Office Responsibility For TOP (F)

Since the claims are established in the Local Office, each claim that appears in ICES must be supported by local office records and the Local Office must be willing to explain the claims to the former recipients. Any funds intercepted in

error will be refunded by the Financial Enhancement Section. All payments made to the Local Office must be posted in ICES within **one working day** to avoid the necessity of making refunds. Voluntary payments made to avoid TOP must be posted as 'VP' (voluntary payment).

The Local Office should ask for payment in full or a minimum payment per month of $50 or 3% of the original claim amount, whichever is more, until the claim is paid in full. All payments of any amount will be accepted, however the claim will still be considered delinquent if less than the monthly minimum is paid. Such delinquent claims will be put back on the TOP list after 60 days, without further notice.

4635.40.10 Request For TOP Review (F)

A Fair Hearing Request should **not** be accepted for TOP collection efforts. The former recipient's right to a Fair Hearing on any claim is limited to the time frame on the initial BV01. Instead, a review should be done per the following instruction.

The Local Office should review all past due Food Stamp claims to determine if they are legally enforceable and meet the following criteria for TOP:

- Claims have a balance of at least $25, and
- None of the responsible persons are on Food Stamps in Indiana, and
- Not more than 10 years have passed since the initial BV01 was sent unless the claim has a judgement against it, through civil, criminal, or small claims court, in which case there is no 10 year limit, and
- Collection is not barred by bankruptcy, and
- The former recipient is not making payments according to a current agreement.

Provide the former recipient with written notification of the results of your review in a letter that should state either the reason that our intended collection action is incorrect and that the claim will not be referred to TOP for collection, or that "We have determined that our intended collection action is correct because you failed to provide documentation that the claim is not past due and legally enforceable. Therefore we will refer your claim to the TOP for collection, meaning any Federal payments you are entitled to receive may be reduced or intercepted and applied to your claim until the total amount is paid in

full." A state form is being developed. Contact the BV Coordinator in Financial Independence for a copy.

Include the USDA Review information 'If you still believe you do not owe this debt you may request a review of the intended collection action by the United States Department of Agriculture, Food and Nutrition Service USDA, FNS). You may send your request to:

USDA - FNS, Midwest Region
77 West Jackson Blvd.
Chicago, ILL 60604-3511
Tax Offset Review'

'Your request must be received within 30 days of the date of this letter and include your name and Social Security Number. While FNS is reviewing your case your claim will not be referred to TOP for collection. When the review is completed FNS will provide you with a written notice stating its decision and the reason(s) for the decision.

FNS will contact the county for copies of the claims material to review the claim. FNS will send a written notice of the decision to the county.

The FNS will review the claim only once. Send a copy of the FNS decision letter to the Financial Enhancement Section.

4635.45.00 STATE TAX INTERCEPT PROGRAM (F, C)

State tax refunds are calculated by IDOR (Indiana Department of Revenue). IDOR then reviews the file to determine a match/no match of certified candidates provided by FSSA Financial Management (FM) for an offset of taxpayer’s refunds. Priorities as established by IDOR and FSSA are:

IDOR
Child Support
DWD
TANF
FS
CCDF
Housing

The state program is similar to TOP with these exceptions. The letter to the former recipient has a 30 day deadline. The 30 day letter is sent each time the former recipient is certified for intercept and includes a repayment agreement which states the minimum amount acceptable. However, if a repayment agreement was previously signed and all payments have not been made, the former recipient does not have the option to sign another agreement. ALL payments must be current from the previous agreement in order to prevent an offset of their tax return. It is therefore important that

repayment agreements be noted in the claim comments so that refunds will not be erroneously released in the future. If a repayment agreement has never been signed the former recipient may sign the repayment agreement and make the required minimum repayment amount to avoid the tax offset. It is important the former recipients are informed that payments must be made each and every month by due date to avoid tax offset and that they have only one opportunity to sign the repayment agreement.

The former recipient has the right to appeal the tax offset. (f27a) Appeals will not stop the offset, but if the decision is favorable to the former recipient, they will receive a refund from FSSA Revenue Recovery after a hard copy of the decision is received, unless another category is delinquent and notice has been issued, i.e. FS tax offset appeal was found favorable to client, but there was a delinquent debt owed for Section 8 Housing, the offset would then be applied to it.

Questions may be directed to FS/TANF Recovery Specialist at 317-233-0889 or Revenue Recovery Manager at 317-233-1459.

4640.00.00 TRANSMITTAL OF REPAYMENT

All repayments must be made to the designated local office staff who will then enter the repayment on BVPC.

If no referral has been made prior to the repayment, the caseworker must complete the referral screen BVBR and forward the paper case file to the BV unit immediately so the claim can be established and repayments can be accepted.

A receipt must be provided to the AG for any payments made by cash, money order, certified check, food coupon or EBT voluntary repayment. A receipt is not given for payments made by benefit reduction. For more information about voluntary EBT repayments, see Section 4635.05.05.

4645.00.00 ENDING COLLECTION ACTIVITY (F)(C)

Collection activity is terminated when certain events occur which make it virtually certain no further payments will be received.

4645.10.00 TERMINATING COLLECTION (F, C)

Bankruptcy:

Local Offices shall act on behalf of, and as, USDA-FNS in any bankruptcy proceeding against bankrupt AGs owing Food Stamp claims. Local Offices shall possess any rights, priorities, interests, liens, or privileges, and shall participate in any distribution of resources, to the same extent as USDA. Acting as USDA-FNS, Local Offices shall have the power and authority to file objections to discharge, proofs-of claims, exceptions to discharge, petitions for revocation of discharge, and any other documents, motions, or objections which USDA-FNS might have filed. Local offices have this authority for TANF claims, too.

- When an overpayment claim is listed as a debt in a bankruptcy proceeding, the Local Office or the Central Office will receive a notice entitled Order for Meeting of Creditors and Fixing Times for Filing Objections to Discharge and for Filing Complaints to Determine Dischargeability of Certain Debts, Combined with Notice Thereof and of Automatic Stay.

  Upon receipt of this notice by the Local Office, the Local Office should stop collection immediately and then consult immediately with their legal counsel and send a copy of this order with a cover memo to the Central Office Financial Management Section, 402 West Washington Street, Room E442, Indianapolis, Indiana 46204. Certain acts and proceedings against the debtor are automatically stayed. (11 USC Section 364(a)) Before further collection activity is continued or initiated, the Local Office must get an exception to the stay. The criteria for obtaining an exception to the stay are set forth in 11 USC Section 362(b). Under the provisions of this subsection, it is unlikely that an exception to the stay could be sought in good faith and it most likely would not be granted even if sought, unless the claim is IPV.

- The Local Office will consult with its legal counsel regarding the filing of an objection to the discharge of the debt or the filing of a complaint to determine dischargeability. 11 USC Section 523 provides for certain exceptions to discharge. Subsection (a)(2)(B) might cover the Food Stamp claims determined to be IPVs if all criteria set out therein were met. The Order referenced in the above subsection will specify deadlines by which objections and complaints must be filed.

- Claims **other than IPV/fraud** will most likely be dischargeable. For IPV/frauds, contact John Wood, Office of General Counsel, W-451, IGCS.

- Whether to seek an exception to the discharge **must be carefully evaluated** because 11 USC Section 523(d) provides for a judgment against the creditor for costs and attorney's fees if the court finds the position of the creditor in requesting a determination of dischargeability was not substantially justified.

- If the bankruptcy results in discharge of the claim (release of the debt) and all liable individuals are parties to the Bankruptcy, then the Local Office will list this claim as terminated (status 'TB' on BVRC). If there is a liable individual who is not a party to the bankruptcy, do **NOT** use status 'TB'. Instead, go to BVLI and use 'BD' to delete the bankrupt individual; this leaves the claim open for the non-bankruptcy liable individuals.

- If the bankruptcy results in a distribution of assets where the DFC is allotted an amount of that distribution, the amount collected shall be credited against the claim overpayment. Claims in 'TB' status can be re-opened if necessary.

- If an exception to the discharge is obtained by the Local Office or the Central Office Counsel, the Local Office will be informed and shall resume collection.

- Bankruptcy does not terminate pending Food Stamp IPV disqualifications.

Paid-in-Full:

When a claim is paid in full an alert will be generated to the caseworker who will run AEABC to authorize the change if no further claims exist. If other claims exist, recoupment is to be initiated on the next claim(s).

NOTE: The Local Office may not collect more than the total amount of over issued benefits unless a court orders interest payment. In the event of court ordered interest, the Local Office should contact the Central Office Financial Management Section for instructions.

Death of All Adult AG Members:

The Local Office will terminate a claim against an AG when all liable individuals who were members of the AG at the time the over issuance occurred have died, leaving no estate or redeemable property.

Terminated Claims:

A Food Stamp claim may be determined uncollectible and subject to termination when it is ten years old and there is no court judgement. The ten years are counted from the establishment of the claim (the date the initial BV01 notice is sent). For converted claims the 10 years will be measured from the discovery date. There is no time limit for TANF and Medicaid claims, however all claims over 10 years old with a balance under $25.00 will be terminated. Voluntary payments on this type of terminated claim will be accepted or restorations due an AG may be used to offset a terminated (status TR) claim.

If the liable individual on a TR-terminated claim again becomes a recipient, allotment reduction will be resumed. On BVRC, the "TR" status should be changed to "OP". Then the recoupment can be added on BVCP. However, the terminated claim that is re-activated will never be subject to TOP again.

4645.15.00 REOPENING SUSPENDED CLAIMS

A claim where collection efforts have been suspended should be reactivated if an AG having a liable person reapplies and is eligible. Benefit reduction should be initiated to begin AFTER the first month's benefits.

If the non-recipient AG voluntarily makes a payment or if repayment occurs as a result of TOP a claim is taken out of suspense by entering "OP" - Open, on BVRC.

4645.20.00 TRANSFER OF CLAIMS (F, C)

When the caseworker learns that an uncollected claim exists in another Indiana county or another State that claim may be transferred to the county where a liable person is currently receiving assistance. The procedures vary depending upon whether the claim exists in another Indiana county or in another State. There is no procedure for transferring a TANF claim to or from another state but see 4655.05.20 for entering an out of state TANF IPV.

4645.20.05 Inter-County Claims Transfers (F, C)

When a claim exists against an AG and that AG moves to another county in Indiana, either county may discover the need to transfer the claim. If the county in which the

claim exists discovers that the AG has moved they may transfer the claim by entering the new county's numerical code in "new county" field on BVBR. This is only to be done if the claim status on BVRC is OA, OP, PR or SU. If the status is "RF" or "PD", the original county must process the case to the point that the claim is opened. The original county should then send a mail message to the benefit recovery coordinator in the receiving county that they are mailing all the claim file information to the receiving county. The benefit recovery coordinator may be determined by entering RFDI in the next Tran and TCRD in the Parms.

If the new county learns of the existing claim they may send a mail message to the benefit recovery coordinator in the original county requesting the claim be transferred to them. However, there is no reason to transfer a claim on which no current payments or recoupment is being made unless the claim materials are in the case file being transferred.

4645.20.10 Inter-State Claims Transfers (F)

Food Stamp claims may be transferred from one State to another to increase the possibility of full claims collection.

If another State with a claim against an individual or group of individuals, learns that they are receiving Food Stamp benefits in Indiana, that State may contact the County in which the AG is participating. They will inquire as to whether the Indiana County will accept the claim. If the county agrees to accept the claim, the other State will send copies of all claim material, including any recomputed budgets to the county. When the County receives this material, the claim is to be converted to ICES being sure to complete the TF field on BVBR.

If it is discovered that an individual or group of individuals for whom a claim exists in Indiana is receiving Food Stamp benefits in another State, the county is to contact the out-of-state County where the liable individuals are receiving Food Stamps and ask if that County will accept the claim. If the out-of-state County is unknown, it will be necessary to call that State agency to determine in which County the individuals are active. The Indiana County is then to copy all related claim material and send it to the out-of-state county. The claim status on ICES (BVRC) should be changed to "TT" - transfer to another State. If a review of the claim material indicates that sufficient documentation does not exist, the claim should be cancelled and no effort made to transfer the claim.

Once a claim is transferred to another State, any funds collected by the receiving State belong to that State and

the USDA-FNS. None of the repayment will be diverted to the State that originated the claim.

4645.25.00 REVERSED DISQUALIFICATION (F, C)

In cases in which the determination of IPV is reversed by a court of appropriate jurisdiction, the disqualification must be reversed and the County Office must reinstate the individual in the program if the AG is otherwise eligible. If benefits were lost as a result of the disqualification they must be restored.

IPV claims cannot be put in “RE” (revision) status in order to be changed and re-opened. In order to reverse the disqualification the BV worker should go to ICES screen BVCP and enter "Y" in the “Cancel Claim?” field. The "reason for cancel" field must be completed with a reason code from ICES table TBRC. Reason code 914 causes a refund in payments collected and should not be used unless the reversal order contains an order to invalidate the claim. If the claim is to be re-entered as an inadvertent or agency error, the payments must first be reversed out on BVTR before the claim is cancelled. After the claim has been re-entered and opened, the payments can be added to the new claim on BVPC. The worker should then access screen BVFV and put an "X" in the "delete latest violation" field. This will delete the IPV information from ICES. The disqualification will be deleted from the DEDR screen the following month.

4650.00.00 CLAIMS AGAINST THE ESTATE (MED)

Under the provisions of the Social Security Act (42 USC 1396p) the state is required to recover certain Medicaid benefits correctly paid on behalf of an individual from the individual's estate.(f28) The circumstances under which a recovery claim must be filed are explained in this and the following sections.

Upon the death of a Medicaid recipient, the total amount paid for medical coverage, except as explained in Section 4650.05 and Section 4650.20.10, is allowed as a preferred claim against the estate of such person in favor of the state. All assets owned by the deceased individual at the time of death, including both real and personal property, become a part of the estate, even if no probate proceedings are initiated in court. The estate does not include property held jointly with rights of survivorship, property held in trust, or life insurance proceeds paid to the deceased's survivors or other beneficiaries.

The claim provision is applicable to all categories of MA, including the categories providing limited coverage, except for SLMB (MA J) and QI (MA I and MA K). This exception applies to recipients who die on and after May 1, 1999 and

is applicable to the state's payment of the Medicare premiums. Amounts paid for Medicare premiums under any MA Category will not be recovered from the recipient's estate. For recipients whose death occurred before October 1, 1993, the claim includes benefits paid for services provided after the recipient became 65 years of age. For recipients whose death occurs after October 1, 1993, the claim includes benefits paid for services provided

1) after the recipient became age 55 if the services were provided after October 1, 1993, and

2) after the recipient became age 65, if the services were provided before October 1, 1993.

In addition, a claim against the estate can be filed for the amount of Medicaid benefits "incorrectly paid" on behalf of a recipient regardless of age.(f29) It is not required that there be a previous court judgment as to the amount of Medicaid benefits incorrectly paid. However, the existence of such a court judgment would expedite the probate proceedings when the claim against the estate is filed.

4650.05.00 NON-ENFORCEMENT OF CLAIM (MED)

If a spouse survives the recipient, recovery shall be made after the death of the surviving spouse. Only those assets that were included in the recipient's probate estate are subject to recovery after the surviving spouse's death.

If the recipient (or the recipient's spouse upon his or her death) is survived by a dependent child, no recovery shall be made while the child is under age twenty-one (21) or is a dependent who is non-supporting due to blindness or disability by SSI standards.(f30a)

In addition a claim may not be enforced against the personal effects, ornaments, or keepsakes of the deceased.(f31)

Resources that are protected under the Indiana Long Term Care Program (ILTCP) are not subject to recovery from the recipient's estate. Refer to Section 2615.25.15 concerning the ILTCP.(f32a)

A claim may be waived if it is not cost effective to pursue the claim. If the cost of collection is equal to or exceeds the amount that can be collected, then it is not cost effective to pursue the claim.

4650.10.00 FILING THE CLAIM (MED)

Estate administration may be accomplished using one of the following three procedures: supervised administration (the normal procedure), unsupervised administration, or by a "no

administration" procedure. The process for filing claims depends on the type of estate administration procedures used.

When estates are administered under the supervised and unsupervised administration procedures, the probate court first appoints a personal representative to administer the estate. The personal representative then "opens" the estate. Once an estate is opened for probate, a notice to creditors is published in the legal notices of a local newspaper of general circulation. After published notification, there is a five-month period during which creditors of the deceased individual may submit claims against the estate. While the five-month time limit does not apply to governmental entities, it is important for the local office to submit claims as soon as possible. The local office should file the claim within five-months whenever possible.

A systematic and regular review of the legal notices and the probate docket of the county probate court are to be made by the local office to ascertain whether or not an estate has been opened for any deceased MA recipients. As soon as the local office learns that an estate has been opened, the local office should initiate the process for filing a claim with the probate court.

Estates with a gross value under $25,000 and meeting certain other legally established conditions, may be settled using the "no administration" procedure. In these cases, there are no probate court proceedings, and a claim by small estate affidavit may be used to claim assets.

A claim by small estate affidavit cannot be made until forty-five (45) days have elapsed since the death of the decedent. The affidavit must be made by or on behalf of the local office and state the following: 1)the value of the gross probate estate wherever located (less liens and encumbrances) does not exceed twenty-five thousand dollars ($25,000); 2) forty-five (45) days have elapsed since the death of the decedent 3)no application or petition for the appointment of a personal representative is pending or has been granted in any jurisdiction; and 4) the claimant is entitled to payment or delivery of the property.(f33)

When preparing a claim, the local office is to request from the Office of Medicaid Policy and Planning (OMPP), via State Form 6533, Medicaid Expenditures Request, the total amount of Medicaid expenditures paid on behalf of the individual. The address is: OMPP, ATTN: Estate Recovery, 402 W. Washington, Room W-382 MS 07, Indianapolis, IN 46204. The claim against the estate should be filed with the Clerk of the Probate Court as soon as possible. (However, when a small estate claim affidavit is used, it is presented to

whoever is holding assets of the deceased, and is not filed with the Clerk of Probate Court). The form on which the claim is filed may be obtained from the Clerk of the Probate Court (usually the County Clerk).

4650.10.05 Recovery From Special Needs Trusts (MED)

Funds remaining in a "special needs trust", as defined in Section 2615.75.20.05, are to be recovered after the recipient's death.

These claims will not require the preparation of an affidavit or filing with the probate court. Because the terms of the trust require the trustee to pay any remaining funds to the state up to the amount of Medicaid expenditures, the state's claim is to be presented to the trustee for payment. This is accomplished by letter to the trustee signed by the local office director with documentation of expenditures attached. The claim includes all Medicaid expenditures on behalf of the deceased, regardless of age.

4650.15.00 OPENING AN ESTATE (MED)

If an estate is not opened and the heirs have no intention of doing so, any interested party (such as a creditor) may petition the court to open an estate and to request the appointment of an administrator. Prior to petitioning the court, these cases should be evaluated by the local office in conjunction with the local office attorney, to determine if there are sufficient assets in the estate to offset the cost of opening and administering the estate. If not, opening an estate should not be initiated.

Cases in which there are sufficient assets should be referred to the local office attorney to prepare and file with the court, a petition to open an estate and appoint an administrator.

4650.20.00 PRIORITY OF THE CLAIM (MED)

Payment of debts from resources in the estate of the decedent is made in accordance with legally established priorities. Priority in the payment of claims is important whenever the estate of the deceased is insolvent (such as when the total amount of all claims against the estate exceeds the assets of the estate). If the amount of the DFC claim is not satisfied in full after distribution of the estate assets, such debt must be considered cancelled.

The local office attorney should be consulted regarding the order of priority of the DFC claim in relation to that of other claimants.

4650.20.05 Compromise Of Claims (MED)

IC 4-6-2-11 provides "No claim in favor of the state shall be compromised without the written approval of the governor and the attorney general, and such officers are hereby empowered to make such compromise when in their judgment, it is the interest of the state so to do."

This applies to situations where the State agrees to accept less than the amount that is available and to which it is legally entitled. If the estate is insolvent and the State will receive the entire balance of the estate after payment of claims that have higher priority, that is not a compromise and it does not require the approval of the governor and attorney general.

The settlement must be in the State's best interest. In most cases for which a compromise is approved, there is some reason that the claim would be risky to pursue. Some examples are when 1) another claim arguably has priority such as expenses of last illness, 2) there is a dispute as to the amount of the claim, or 3) the asset is a land contract or other asset that is not easily liquidated and the State agrees to accept cash in a lesser amount.

Procedure for Approval

The local office or the local office attorney should submit to the Office of Medicaid Policy and Planning (OMPP), attn: Estate Recovery Specialist, in writing, the following information: 1) the amount of the claim, 2) available assets in the estate, 3) the proposed settlement, and 4) the reason for settlement, and 5) why it is in the best interest of the state to accept the settlement. OMPP will forward the information to the collection section of the attorney general's office for final action.

4650.20.10 Waiving Estate Claims For Undue Hardship (MED)

The Medicaid program's claim against the estate of a deceased recipient must be waived if enforcement of the claim would result in undue hardship for an heir. (f34) The decision to approve or deny an application for a waiver of the estate recovery claim will be made by the Office of Medicaid Policy and Planning based on information provided by local office staff and the local office attorney in accordance with the following procedures.

1. At the time a claim is filed, a Notice is to be included with the claim, explaining the undue hardship provisions and the process for applying for a waiver of the state's claim. An application (State Form 48259/OMPP 003) is to be provided upon request to an heir who wishes to apply for a waiver.

2. The hardship applicant will complete the form and return it, along with supporting documentation, to the attorney or designated local office staff person. The applicant must indicate one of four situations as the basis for his claim:

    a. Enforcement of the state's claim will cause the applicant to become eligible for public assistance;
    b. Enforcement of the state's claim will cause the applicant to remain dependent on public assistance;
    c. Enforcement of the state's claim will result in the complete loss of the applicant's sole source of income and the beneficiary's income does not exceed the Federal Poverty Level (FPL);
    d. Other compelling circumstance (the applicant must describe).

3. If the applicant indicates only the last category, other compelling circumstances, the application is to be immediately forwarded to the Office of Medicaid Policy & Planning, attn: Estate Recovery Specialist, Indiana Government Center South, 402 West Washington St., Indianapolis, IN 46204. If any of the other three situations are checked by the applicant, the local office must make the appropriate determination, attach all documentation to the application and forward it to the OMPP.

4. If the applicant specifies hardship category 2a or 2b, the local office must determine if the hardship applicant would be eligible for TANF, Medicaid, Food Stamps, or SSI if he/she loses access to the asset(s) in the deceased recipient's estate. The caseworker's determination must show the eligibility result as if the applicant owned the asset and as if he did not own it. For example:

A recipient and his non-disabled son live together on a farm. The son works on the farm and his father shares the farm income with him. The property is in the recipient's name only and when he dies the property becomes subject to estate recovery. The son, who is beneficiary of the estate, applies for a hardship waiver claiming that without the income from the property, he will become eligible for Food Stamps. The local office must make a Food Stamp eligibility determination. (The son does not need to actually file a Food Stamp application.) The caseworker determines that if the applicant were to own the farm, he would not be eligible for Food stamps due to the income he would have from the farm. Without the farm and its income, he meets Food Stamp eligibility requirements. Therefore, if the state enforces its claim against the estate, the son would become eligible for assistance.

In the above example, assume that father and son do not live together. The son is employed and he and his family receive Food Stamps. When his father dies, he files a hardship application claiming that if he could be allowed to inherit the farm he would no longer need Food Stamps. The caseworker's determination shows that if he owned the farm he would lose Food Stamp eligibility.

The hardship applicant is responsible for providing all necessary verifications. Caseworkers should apply the usual verification requirements in a hardship determination, and inform the applicant in writing of the documentation that he must provide to substantiate the hardship claim. The caseworker will need to inform the applicant of the various types of acceptable verification, however the responsibility for obtaining the verification rests solely with the applicant. The determination must be made within 30 days of receipt of the application and forwarded to the OMPP. If the applicant does not provide necessary verification within 30 days, the caseworker must indicate such in a letter accompanying the application to the OMPP. The letter should specify the verifications that the applicant failed to submit and a copy of the caseworker's notification to the applicant concerning the need for verifications should be included.

5. If a hardship applicant claims that his only source of income comes from the property in the estate, the caseworker must determine whether or not that income is less than the FPL. The standards effective 2/24/98 are as follows:

Family Unit	Annual Standard

1	$ 8,050
2	10,850
3	13,650
4	16,450
5	19,250
6	22,050
7	24,850
8	27,650
Each additional, add	2,800

For this determination, "family unit" is defined as a group of persons related by birth, marriage, or adoption who live together. In determining the amount of income to compare to the standard, the caseworker will consider: 1) gross income from employment, 2) all unearned income, and 3) net self-employment income and rental income in accordance with the methodologies used for the aged, blind, and disabled Medicaid categories. The applicant is responsible for providing the necessary verifications.

6. The Office of Medicaid Policy and Planning will make a decision to approve or deny the application and will issue a Notice of Action, State Form 48260/OMPP 0004, to the applicant within 45 days of the application date. A copy of the notice will be sent to the local office attorney. An applicant has the right to appeal the decision.

4655.00.00 TRACKING IPV DISQUALIFICATIONS (F, C)

The Disqualified Recipient Subsystem (DRS) is a Federal program in which States are required to participate. The purpose of DRS is to track IPV disqualifications both pending and already served, nation wide.

In Indiana, data for DRS is tracked on BVFV. This screen is completed by the BV worker and provides information about pending disqualifications including the disqualification number and the number of months in the disqualification period. Screen BVPI which may also be completed by the BV worker supplies information about IPV disqualifications established and served prior to the individuals entry into ICES. The information on BVPI is necessary to determine the length of any future disqualification periods. The information on BVFV is used by ICES to generate an alert informing the worker to run ED/BC to disqualify the individual. In order for an IPV disqualification to be imposed the county must have a copy of the ADH decision, Waiver of ADH, judicial review or Disqualification Consent Form, and a copy of the Notice of Disqualification.

If an IPV disqualification is in effect in Indiana or in another State that information will appear on DEDR. An alert will appear to inform the worker that a

disqualification may exist. During application processing, screen DEDR will appear on any case containing an individual with a disqualification.

DEDR must be reviewed to determine if the person listed as disqualified in another State is the same individual that is appearing in ICES. If it is determined that there is a match the County must immediately contact the contact person in the other State and request a copy of the decision and the notice of disqualification. The contact person and the contact person's phone number are listed on DEDR. The disqualification cannot occur until the County receives this documentation. Authorization of the case may not be delayed in order to receive this information so it is vital to request this documentation as soon as the pending IPV is discovered.

The County should also ask the other State if a claim exists and the status of the claim. The other State has the option of transferring the claim to Indiana. See Manual Section 4645.20.00.

4655.05.00 ENTERING IPV DISQUALIFICATIONS (F)

Once it has been determined that an IPV disqualification exists the BV worker must enter this information on ICES. A new IPV disqualification cannot be entered unless a claim already exists. If there is no claim balance to enter, a $0 claim must be established. IPV is the only claim status which allows $0 claims. Care must be taken to close the zero balance claim after the disqualification has been entered. A previous disqualification from another state can be entered on BVPI without entering a claim.

4655.05.05 Entering Disqualifications At Application (F)

When an IPV disqualification is discovered at application processing and the disqualified individual has applied for the program for which the IPV exists, and ICES does not already contain a claim for the pending IPV disqualification the County is to enter the claim while the application is still pending. This is the only situation in which this may be done. This will allow entry of IPV information discovered through the DEDR screen while the case is still pending. Once the case is authorized, the IPV disqualification can then begin. Recoupment is not to be deducted from the initial benefits including the current month and any previous months authorized at application.

4655.05.10 Entering Disqualifications During Certification (F)

If the individual is already certified for Food Stamps when a current IPV is discovered use standard claims procedures

when entering the claim unless no claim amount exists. In this situation use BVPI to enter the disqualification.

4655.05.15 Entering Prior Disqualifications (F)

Individuals who have served an IPV disqualification before they became know to ICES, whether in Indiana or in another State as shown on screen DEDR are to have the disqualification(s) entered on BVPI. BVPI is to be accessed directly, BVBR and BVRC are not accessed and a claim is only to be established if there is an outstanding claim balance. BVPI is used to determine the length of any subsequent IPV disqualification.

4655.05.20 Entering Out-Of-State IPVS (C)

If an individual has been found guilty of an TANF Intentional Program Violation (IPV) in another state, the disqualification(s) must be entered into BVPI after copies of the disqualification findings and notices of disqualification have been obtained from the other state. The disqualification for these IPVS cannot be imposed; but if the individual is found guilty of committing an IPV in Indiana, the violations committed in other states will be used in determining the length of any subsequent TANF IPV disqualification.(f35)

4655.10.00 REQUESTS FROM OTHER STATES REGARDING DISQUALIFICATIONS (F)

Disqualification information from Indiana is being made available from ICES to the DRS - Disqualified Recipient Subsystem, for distribution to other State agencies.(f36) Representatives from these agencies will phone requesting copies of disqualification findings and notices of disqualification. It is important that copies of these documents be sent within 24 hours of the request. The original documents must be retained at the local office.

4699.00.00 FOOTNOTES FOR CHAPTER 4600

Following are the footnotes for Chapter 4600:

(f1) 7 CFR 273.18(a)(ii)
(f2) 470 IAC 10.1-12
(f3) 470 IAC 14-3-7
(f4) IC 12-15-2-19
(f5a) 45 CFR 233.20;
(f5b) 470 IAC 14-3-7
(f6) 42 CFR 431.230
(f6a) 7 CFR 273.16(b); Section 13942 of P.L. 103-66
(f6b) 470 IAC 14-3-7
(f7) 7 CFR 273.18(c)(1)(i)
(f8) 7 CFR 273.18(d)(1)

(f9) 7 CFR 273.18(c)(2)
(f10) 7 CFR 273.18(e)(2)
(f11) 7 CFR 273.18(a)(4)
(f12) 45 CFR 233.20 (a)(13)(i)(A)(1) and (B)
(f13) Social Security Act, Section 415; 45 CFR 233-52
(f14) 45 CFR 233.52
(f15) 470 IAC 10.1-5-2
(f16) 7 CFR 273.11(e)(6)
(f17) 7 CFR 273.18(e)(3)
(f18) 470 IAC 10.1-5-2
(f18a 7 CFR 273.18(g)(9)
(f19) 7 CFR 273.18(g)(2)
(f20) 7 CFR 273.18(g)(1)(ii)
(f21) Social Security Act, Section 402 (a)(22); 45 CFR 233.20
(f22) 470 IAC 10.1-5-2
(f23) 45 CFR 233.20
(f24) 7 CFR 273.17
(f25) Social Security Act, Section 402 (a)(22); 45 CFR 233.20
(f26) 42 CFR 433.36
(f27) IC 33-11.6-4-13
(f28) IC 12-15-9-1; Social Security Act, Section 1917(b)(1) as amended by P.L. 103-66 (OBRA-93)
(f29) IC 12-15-2-19
(f30) IC 12-15-9-5
(f31) IC 12-15-9-2
(f32) 405 IAC 2-8-1(e)(2)
(f33) IC 29-1-8-1
(f34) IC 12-15-9-6; 405 IAC 2-8-2
(f35) 45 CFR 235.112(c)(3)
(f36) 7 CFR 273.16(h)(2)(i)